Medical Records Release Form

I do hereby consent and authorize the release of my medical records.

Patient Name: ______________________________________ Date of Birth: ___________________

Address: _________________________________ City, State, Zip: ___________________________

Phone: __________________________ Social Security Number (last 4 digits only): XXX-XX-__________

Records Requested From

Name of Person or Facility: ____

Practice Address: ____

City, State, Zip: _______________________Phone: _________________ Fax: __________________

Records to Use or Disclose To

Name of Person or Facility:____

Practice Address: ____

City, State, Zip: _____________________Phone: ____________________ Fax: __________________

Please select all the specific documents that apply to your request:

__ Clinic Notes

__ Radiology Reports

__ Nurses Notes

__ Emergency Room

__ Progress Notes

__ Lab Reports

__ Operative Reports

__ Doctor Consults

__ History & Physical

__ Pathology Reports

__ EKG, ECG, EMG

__ Physician Orders

__ Discharge Summary

__ Urgent Care

__ Radiology Images

__ Other

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Patient Signature: ____ Date: ____________________

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