

## Medical Records Release

<b>Patient Information</b>			
Name (First, Middle, Last):			DOB:
Address:	City:	State:	Zip:
Phone #:	Email:	Medical Record #:	

## Records Request Details

<b>Entity Releasing Records</b>			
Entity Name:		Contact Name:	
Address:	City:	State:	Zip:
Phone #:	Fax #:	Email:	

<b>Entity Receiving Records</b>			
Entity Name:		Contact Name:	
Address:	City:	State:	Zip:
Phone #:	Fax #:	Email:	

<b>Information Release Details</b>			
Effective Time Period:			
Purpose of Release:			
Type of Records Being Released (check all that apply):  <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> All Medical Records  <input type="checkbox"/> Urgent Care Notes  <input type="checkbox"/> Operative Notes  <input type="checkbox"/> Discharge Summaries  <input type="checkbox"/> Laboratory Reports  <input type="checkbox"/> Patient Billing Records  <input type="checkbox"/> Emergency Room Notes  <input type="checkbox"/> Progress Notes                             </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Radiology Reports  <input type="checkbox"/> Film/CD Imaging  <input type="checkbox"/> Clinical Notes  <input type="checkbox"/> Nursing Notes  <input type="checkbox"/> History &amp; Physical  <input type="checkbox"/> Providers Orders  <input type="checkbox"/> Consultations  <input type="checkbox"/> Other:                             </td> </tr> </table>	<input type="checkbox"/> All Medical Records <input type="checkbox"/> Urgent Care Notes <input type="checkbox"/> Operative Notes <input type="checkbox"/> Discharge Summaries <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Patient Billing Records <input type="checkbox"/> Emergency Room Notes <input type="checkbox"/> Progress Notes	<input type="checkbox"/> Radiology Reports <input type="checkbox"/> Film/CD Imaging <input type="checkbox"/> Clinical Notes <input type="checkbox"/> Nursing Notes <input type="checkbox"/> History & Physical <input type="checkbox"/> Providers Orders <input type="checkbox"/> Consultations <input type="checkbox"/> Other:	Release of Sensitive Medical Info (check all that apply):  <input type="checkbox"/> Mental Health/Psychiatric Treatment <input type="checkbox"/> Genetic Testing Information <input type="checkbox"/> Alcohol or Substance Abuse Treatment <input type="checkbox"/> STD/HIV/AIDS Treatment(s) or test(s) <input type="checkbox"/> Additional Info:
<input type="checkbox"/> All Medical Records <input type="checkbox"/> Urgent Care Notes <input type="checkbox"/> Operative Notes <input type="checkbox"/> Discharge Summaries <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Patient Billing Records <input type="checkbox"/> Emergency Room Notes <input type="checkbox"/> Progress Notes	<input type="checkbox"/> Radiology Reports <input type="checkbox"/> Film/CD Imaging <input type="checkbox"/> Clinical Notes <input type="checkbox"/> Nursing Notes <input type="checkbox"/> History & Physical <input type="checkbox"/> Providers Orders <input type="checkbox"/> Consultations <input type="checkbox"/> Other:		
Formate: <input type="checkbox"/> Email Address noted above, where permitted <input type="checkbox"/> CD <input type="checkbox"/> Paper copy <input type="checkbox"/> Other:	Delivery Method: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> US Mail  <input type="checkbox"/> Pick-up  <input type="checkbox"/> Fax  <input type="checkbox"/> Email                             </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Overnight/Express  <input type="checkbox"/> Certified  <input type="checkbox"/> Other:                             </td> </tr> </table>	<input type="checkbox"/> US Mail <input type="checkbox"/> Pick-up <input type="checkbox"/> Fax <input type="checkbox"/> Email	<input type="checkbox"/> Overnight/Express <input type="checkbox"/> Certified <input type="checkbox"/> Other:
<input type="checkbox"/> US Mail <input type="checkbox"/> Pick-up <input type="checkbox"/> Fax <input type="checkbox"/> Email	<input type="checkbox"/> Overnight/Express <input type="checkbox"/> Certified <input type="checkbox"/> Other:		

## Patient's Rights

### Patient Rights

I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- I have a right to a copy of this Authorization.

### Authorization

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Representative's Relationship to Patient

\_\_\_\_\_  
Witness (optional)

\_\_\_\_\_  
Date

