MEDICAL RECORDS RELEASE FORM

By signing this from, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or summary or narrative of my protected health information, to the physician/facility/entity listed below.

Patient Name:_____ **Date of Birth**:_____

The information you may release subject to this signed release form is as follows:

☐ Complete Records ☐ Lab Reports ☐ Medication Record

☐ Operative Reports ☐ Pathology Reports ☐ Other _____

Release my medical Records from:

Name: _____

Address: _____

City: State: Zip Code: _____

Phone: _____ Fax: _____

Release my medical Records to:

Name: _____

Address: _____

City: State: Zip Code: _____

Phone: _____ Fax: _____

Signature:

Name: _____ Date:_____
Date of Birth: _____