

# RELEASE OF RECORDS

## Patient Information

Patient Name
DOB
Phone Number
Address

## Records to be released from

Facility / Provider Name
Phone Number
Fax Number

## Records to be sent to

Facility / Provider Name
Phone Number
Fax Number
Address

## Information to be released

- Complete Medical Record
- Office Visit Notes
- Lab Results
- Imaging Reports
- Immunization Records
- Billing Records
- Other: \_\_\_\_\_

## Authorization & Acknowledgment

I hereby authorize the use or disclosure of my protected health information as described in this form. I understand that this authorization is voluntary and may be revoked in writing at any time,

except to the extent that action has already been taken in reliance on it. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

Patient / Legal Representative Signature: \_\_\_\_\_

Relationship to Patient (if applicable): \_\_\_\_\_

Date: