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Records Release

Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Social Security _____

Release Records

From: _____ **To:** _____

_____ _____

_____ _____

_____ _____

P# _____ F# _____ P# _____ F# _____

Information to be Released:

- ☐ Medical Record
- ☐ Diagnostic Testing
- ☐ Mental Health Record
- ☐ Labs
- ☐ Medication List
- ☐ Other: _____

All Service Dates: ☐

Dates of Service: _____ any/all

Signature: _____ Date: _____
patient/parent/guardian

Verification of Information Released

Name and Title of person who released records: _____

- ☐ Sent by mail on (date): _____
- ☐ Faxed To (number): _____ on (date): _____
- ☐ Picked up by (name): _____ on (date): _____

I understand the information disclosed by this authorization may be re-disclosed by the recipient and no longer protected by HIPPA. This office, its employees and physicians are released from any legal responsibility for disclosure of information to the extent indicated and authorized.

The information enclosed herein includes Protected Health information of one or more individuals. This information is highly confidential and is protected by the provisions of the federal HIPPA Privacy Rules. No one except the intended recipient of this information is entitled to see its contents.