



Medical Records Request

1. I AUTHORIZE:

Name of sending person/organization

Street Address

City State Zip Code

Fax Number

2. TO RELEASE TO:

Name of receiving person/organization

Street Address

City State Zip Code

Fax Number

3. **INFORMATION TO BE RELEASED:** (Check all applicable)

- All Information All Progress Notes Lab Reports X-ray Reports
 Electrocardiogram (ECG) Allergy Record Immunization

4. **RECORDS FROM THE TIME PERIOD:** ____/____/____ through ____/____/____

5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)

- Continued Medical Care Personal

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requestor may be provided with a copy of this authorization.

Patient's Name (Please Print) _____

Patient's Signature: _____ Date: _____

Date of Birth: _____

Home Phone: _____