

MEDICAL RECORDS RELEASE

TO: _____

DATE: _____

INFORMATION REQUESTED:

Consultation, History & Physical

Procedure and Operative Reports (Please specify): _____

Laboratory and Pathology Reports (Please specify): _____

Imaging Reports (Please specify): _____

Physician Correspondence/ Letters: _____

Other:

Patient Name (Printed)

Date of Birth

RELEASE

I hereby authorize the release of my health information. I understand that this authorization is voluntary, that all records are confidential and cannot be released without my prior authorization except as otherwise allowed by law. I understand that a photocopy or fax of this authorization is as valid as the original. This authorization expires in one year.

SIGNATURE

DATE OF AUTHORIZATION

Name of Patient Representative, if other than patient Relationship

Medicalrecordsrelease2007