RELEASE OF MEDICAL RECORDS REQUEST

Patient: _____ Date of Birth: _____

Street: _____

City: _____ State: _____ Zip Code: _____

From Doctor/Medical Practice: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

I hereby authorize and request that you release my medical records to:

To Doctor/Medical Practice: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Include the following health records concerning my prior evaluation, illness and/or treatment:

☐ Complete health records	☐ X-Ray reports	Sensitive Records:
☐ History and Physical	☐ Laboratory reports	☐ HIV
☐ Consultation notes	☐ Operative reports	☐ Psychiatric
☐ Procedure notes	☐ Other: _____	☐ Substance abuse

Covering the period:

Date From: _____ Date To: _____

The Health Insurance Portability and Accountability Act, HIPAA, set forth the circumstances under which a Health Care Provider must obtain an individual's authorization before it uses or discloses Protected Health Information (PHI). This authorization may be required for the Health Care Provider's own purposes, or because the individual has made a specific request for the use and disclosure of the PHI. I understand this authorization may be revoked in writing at any time, except to the extent that the disclosure made in good faith has already occurred in reliance of this authorization. Unless otherwise specified, this authorization will expire on: _____

Signature: _____ Date: _____

If relative, print name and state relationship: _____