



Medical Records Release

The following is an authorization for the release of medical information (including, if any psychiatric or psychological information, infectious or contagious disease information, including HIV/AIDS confidential information), and/or information about drug or alcohol abuse treatment from the health records of:

Patient name: _____ DOB: _____

Address: _____

Home Phone: _____ Cell: _____ Work Phone: _____

To be released TO/FROM: (circle one)

Physician/Practice: _____

Address: _____

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Office Notes | <input type="checkbox"/> Labs |
| <input type="checkbox"/> EMG/NCV | <input type="checkbox"/> Radiology | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> ER Records | <input type="checkbox"/> Phone Notes |

Phone: _____ Fax: _____

I authorize the following information to be released:

To be released TO/FROM: (circle one)

Physician/Practice: _____

Address: _____

Phone: _____ Fax: _____

The reason or purposes for this release of information are as follows:

_____ Legal Issues _____ Insurance Claim _____ Personal Use
_____ Continuing Care _____ Other _____

Patient Signature: _____ Date: _____

This release is valid for one year from the date of signature. Please allow 3-5 business days for completion of request.