MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Phone Number: _____ Email Address: _____

1. Authorization to Release Medical Records

I hereby authorize the healthcare provider or entity named below to release my complete medical records, including but not limited to medical history, physical and mental health treatment, diagnoses, prognoses, medications, and billing information, to the designated recipient. This authorization includes all protected health information as required under HIPAA and applicable state laws.

2. Healthcare Provider / Facility to Release Records

Name: _____

Address: _____

Phone Number: _____

3. Recipient of Medical Records

Name or Organization: _____

Address: _____

Phone Number: _____

Fax Number (if applicable): _____

4. Purpose of Disclosure

- ■ Continuity of Care
- ■ Insurance
- ■ Legal
- ■ Personal Use
- ■ Other: _____

5. Specific Information to be Released (Check all that apply)

- ■ Entire Medical Record
- ■ Lab Reports
- ■ Imaging Studies (X-rays, MRI, CT scans)
- ■ HIV/AIDS Related Records
- ■ Mental Health Records
- ■ Substance Abuse Treatment Records
- ■ Genetic Testing Information
- ■ Other Sensitive Information: _____

6. Expiration and Revocation

This authorization shall remain in effect until revoked by me in writing. I understand that I may revoke this

authorization at any time by notifying the healthcare provider or entity in writing, except to the extent that action has been taken in reliance on this authorization. Unless revoked, this authorization will expire upon completion of the purpose or _____ (date or event).

7. Patient Rights and Acknowledgments

I understand that signing this form is voluntary and that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization except as allowed by law. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws. I understand that I have the right to receive a copy of this authorization.

8. Signature

Patient Signature: _____ **Date:** _____

If signed by a personal representative, describe authority: _____

9. Witness

Witness Signature: _____ Date: _____

10. Office Use Only

Verified by: _____ Date: _____

Notes: _____

PATIENT SIGNATURE **WITNESS SIGNATURE**

Signature: _____ Signature: _____