



Medical Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

- | | | |
|--|---|---|
| <input type="checkbox"/> Complete Records | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Care Plan | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Treatment Record | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Hospital Reports | <input type="checkbox"/> Medication Record | <input type="checkbox"/> Other (please specify below) |

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: _____ Address: _____
City, State, Zip Code: _____

The purpose for this release of information is as follows: _____

Signature: _____

Patient Name

Signature of Patient or Personal Representative

Patient Date of Birth or Social Security Number

Printed name of Patient or Personal Representative

Date

Description of Personal Representative's Authority