Hephzibah Health Solutions, LLC

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:

☐ Complete Records	☐ History & Physical	☐ Progress Notes
☐ Care Plan	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Reports	☐ Treatment Record	☐ Operative Reports
☐ Hospital Reports	☐ Medication Record	☐ 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