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Patient Authorization for Release of Medical Records

Patient's Name: _____

Address: _____

DOB: _____

Please check all information that applies:

- ○ Chart Notes
- ○ Lab Results
- ○ X-rays/CAT Scans/MRI/MRA
- ○ Procedure/Pathology Reports
- ○ Other (Please Specify)

_____

I give my authorization to Dr: _____ at fax#_____

to release the above protected information to: _____ fax#

_____

- ○ I am authorizing to disclose or release the above protected information to the following person or organization. The following will receive and use my protected health information:

Name: _____

Address: _____

Fax #: _____

Select one of the following choices:

- ○ This authorization will end on the following date: _____
- ○ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use/or disclosure. Describe the event below:

_____

Signature of Patient: _____

Name of Patient: _____

Date: _____