Medical Records Release Form

(Please Print or Type)

Patient's Name_____ Date_____

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

This information you may release subject to his/her signed release form is as follows:

COMPLETE RECORDS	HOSPITAL REPORTS	TREATMENT RECORD
LAB REPORTS	PROGRESS NOTES	OPERATIVE REPORTS
PATHOLOGY REPORTS	HISTORY & PHYSICAL	MEDICATION RECORD
RADIOLOGY REPORTS	CARE PLAN	OTHER (PLEASE SPECIFIY BELOW)

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infections with any other causative agent of AIDS with the rest of my medical records.

Initial: _____ Date: _____

Release my protected health information to the following to the physician/person/facility/entity:

Name:_____

Address:_____

City_____State_____Zip_____

Phone Number:_____

Fax Number:_____

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

_____

_____ _____ _____

Printed Patient Name Date of Birth Social Security #

_____ _____

Patient's Signature Today's Date