Authorization for the release of Medical Records

Patient Name: DOB: SSN:

I hereby authorize: _____
Name of Doctor or Hospital

_____
Address

_____
City, State, Zip

_____
Phone/Fax

To release to: _____
Name of Doctor or Hospital

_____
Address

_____
City, State, Zip

_____
Phone/Fax

Date/Information to be released

_____ History & Physical _____ Labs
_____ Procedure Notes/Pathology _____ Radiology
_____Progress Notes _____ other (list)

Reason of Disclosure:

_____Continuity of Care _____Insurance Review _____Legal Review _____ For Personal Records

When signing this release to obtain records for personal review, I am agreeing that reports, test results, and notes can only be interpreted by a physician and will not hold _____liable for any misinterpretations of the information. _____initials.

Authorization:

I understand that this authorization is valid for 90 days after the date of my signature. I have the right to revoke this authorization at any time with understanding that all or part of this information may have been used in good faith to revocation. I understand that unless otherwise indicated, all information including psychiatric records, sexually transmitted disease, and communicable diseases will be released. A photocopy of this consent shall be considered as valid as the original.

Signed:_____ Date: _____
Patient/Relationship to Patient

_____
Witness