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Medical Records Release Form

Patient Name: _____ Date of Birth: _____ Phone: _____

Address: _____

I hereby authorize: _____

To send/release photocopies of medical records concerning the above patient to:

Name/Practice: _____

Address: _____

For the purpose of: _____

Medical Records (Check all that apply):

- Pathology Reports Lab reports last Visit note CCD (sent via direct mail)
- Only "Minimal Necessary" record information HIPPA
- The following described records only (specify type/date(s))

This authorization is valid for 60 days after the signed date below. I may revoke this authorization at any time providing written notification is provided. I agree that a photocopy of this verification is as valid as the original. I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

Exclude the following information from the records released (please initial):

- Drug/Alcohol Abuse/Treatment Sexually Transmitted Disease
- HIV/AIDS diagnosis treatment/testing Mental Illness or psychiatric Diagnosis/Treatment

Signature: _____

Date: _____

Patient, Guardian or Authorized Representative