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Authorization for Release of Records

Patient Name _____
Patient Address _____
Patient Phone Number _____
Patient Date of Birth _____

Where do you want records released to?

Name (if other than to patient): _____
Address (If record is to be mailed): _____

Fax (If record is to be faxed): _____
Contact Phone Number: _____

Generally requests of this nature are granted within 30 days of receiving this notice. If for any reason this request cannot be granted we will give you written notice.

I authorize the release of my medical records to said person(s) named above.

Signature of Patient, Parent, or Guardian

Date

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____