Medical Records Release Authorization Form

Patient Information

Full Name

Date of Birth

MM/DD/YYYY

Phone Number

Address

Release Information

Release Records From (Doctor/Facility Name)

Provider Address / Contact

Release Records To (Name/Organization)

Receiver Address / Contact

Information to be Released

☐ All Medical Records ☐ Records from From to To ☐ Other (specify):

Describe specific records, if any

Purpose of Disclosure

e.g., Continuation of care, insurance, personal

Authorization & Signature

I understand that this authorization will remain in effect for one year or until I revoke it in writing.
I understand that authorizing the disclosure of this information is voluntary.

Patient Signature

Sign here

Date

MM/DD/YYYY

Legal Representative (if applicable)

Relationship to Patient

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations.