



Medical Records Release

Date _____

Please Print Clearly in Black Ink

Patient Name _____

Patient Date of Birth _____ Patient Account # _____

I, _____

Hereby authorize _____

To release to _____

The following medical information from my personal medical records:

- Entire record
- X-ray/diagnostic reports
- Laboratory results
- Consultation reports
- Most recent history and physical
- Other _____

I give permission for this medical information to be used for the following reason

Please list any restrictions to the use of the medical record

Patient Signature _____ Date _____

Witness Signature _____

This authorization is good for one year from the date above, unless otherwise revoked.