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RECORDS RELEASE FORM

This form is to confirm your authorization to release the following information from your medical records

Individual patient (or representative) confirming the authorization.

I give my permission to release my protected health information as described below**.

Individual Patient's Name_____

Address: _____

_____

Home Phone _____Alt Phone _____

Social Security Number _____ Date of Birth _____

**The use and/or disclosure authorized
Describe in detail the protected health information you are authorizing to be released and/or disclosed:

(__) Copy of complete medical records (__) X-ray/X-ray results

(__) Lab Results (__) Other

_____

_____

Name the people and/or organization(s) that you are authorizing to use and/or receive and use your protected health information.

Name _____ Phone _____

Address _____

_____

Signed: _____ Date: _____