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## MEDICAL RECORDS REQUEST

### REQUEST FROM:

Physician Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State \_\_\_\_\_

Request is made for a copy of all medical records for:

Patient Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City/State \_\_\_\_\_

### TO BE RELEASED TO:

Physician Name: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/Address: \_\_\_\_\_

I understand that this authorization authorizes the release of all medical records, to be faxed or mailed including Psychiatric, Alcohol, Drug Abuse and HIV/AIDS records.  
The use of this information may be protected by Public Law 93-255, Section 408; Public Law 93-282, Section 333; or Federal Regulation 42 CFR, Part 2. The information provided is confidential and any redisclosure by the recipient is prohibited.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

\*\*\*\*\*all medical records will be released unless specific dates are requested\*\*\*\*\*

Records: \_\_\_\_\_ mailed \_\_\_\_\_ picked up \_\_\_\_\_ faxed \_\_\_\_\_

EMPLOYEE INTIALS \_\_\_\_\_