MEDICAL RECORDS REQUEST

REQUEST FROM:

Physician Name: _____

Address: _____

City/State: _____

TO BE RELEASED TO:

Physician Name: _____

Name: _____

Address: _____

City/State: _____

Patient Name: _____

Date of Birth: _____

Address: _____

City/State: _____

_____ _____

Patient Signature Date

_____ _____ _____

Patient Representative Relation to patient Date

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.

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

Employee Initials: _____