Release of Medical Information

I, _______________________________,with a date of birth,________________, give my permission for
(patient name) (patient's DOB)
_________________________________to give my medical records to ____________________________
(doctor's or hospital name who has records) (my doctor's name)

so that he/she can better understand my condition and help me.

Name of Physician:___________________________________

Fax number:____

Address:_______________________________City_______________________State______Zip__________

Permission to get sensitive information:

By putting my initials by each item below, I understand that I give permission for records to be sent that may contain information about:

___ my mental health ____transmittable disease I may have like HIV/AIDS
___ genetic records ___and/or drug and alcohol records

I understand that:

I do not have to give my permission to share these records.
If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.
This form is only good for 3 months from the date I sign it.

Types of records we are requesting:

☐ Any and all types of records you have for this patient

☐ Doctor visit notes
☐ Emergency Room notes
☐ Urgent care notes
☐ History and physical
☐ Hospital Progress Notes
☐ Operation or procedure notes
☐ Clinic notes
☐ Pathology reports
☐ Doctors orders
☐ Nurses notes
☐ Discharge Summary
☐ Lab reports
☐ Radiology Reports
☐ Consultations
☐ Other ________________________________

Records within the following dates:

☐ All records for this patient ☐ Records dated between ______________and _________

Patient's Signature____ Date _____________

Authorized Representative's Signature_________________________ Date______________

Relationship of Authorized Representative____