



# Medical Records Request or Release

## Release of Records

Records to be sent to the following address:

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Reason for Release of Records \_\_\_\_\_

## Request for Records

Records to be received from:

Physician/Facility \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Release from my medical records the following information for the following dates:

From \_\_\_\_\_ To \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**As part of the medical record, the following information will be released unless crossed out:**

**SEXUAL ABUSE INFORMATION**

**DRUG & ALCOHOL ABUSE INFORMATION**

**CHILD ABUSE & NEGLECT INFORMATION**

**PSYCHIATRIC INFORMATION**

**AIDS/HIV**

I have carefully read this consent, understand its contents and authorize the release of the above-specified information. This information is for the person/facility to which it is addressed only. The confidentiality of this information is protected by federal law. The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire in one year from date of signature.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Patient, Parent or Guardian

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**If the patient is unable to sign due to mental or physical disability or is a minor, authorization must be signed by the legal guardian.**