Release of Medical Information

Permission to get records

I, _____,with a date of birth, _____, give my permission for
(patient name) (patient's DOB)

_____to give my medical records (as described on p. 2) to
(doctor's or hospital name who has records)

_____so that he/she can better understand my condition and help me.
(my doctor's name)

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.

Consent for release of medical records for _____
(patient name)

Date: _____

Requesting records FROM:

Name of Practice:_____

Name of Physician:_____

Fax number:_____

Address:_____

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 _____**

Please send records TO:

Name of Practice:_____

Name of Physician:_____

Fax number:_____

Address:_____

Patient's Signature_____ Date _____

Authorized Representative's Signature_____ Date_____

Relationship of Authorized Representative_____