Medical Release Form

PLEASE FILL OUT THE FORM COMPLETELY

Patient Name: _____ Date of Birth: _____

Permission is hereby granted for Release of Information

***From:** Name: _____
(Medical Provider Holding Records)

Address: _____

City: _____ State: _____Zip Code: _____

***To:** Name: _____

Address: _____

City: _____ State: _____Zip Code: _____

Phone #: _____Fax #: _____

***Please mark what you are requesting:** Chart Notes X-Rays (disc or printed) Other: _____

*The purpose for the release is _____

*Transfer of care? ___YES___NO

*How would you like your records? Email: _____ Call to pick up (ph #): _____

Mail (address): _____

*The following dates of service: From _____Through_____

*This permission expires 6 months from the date signed or_____
Specified Expiration Date

_____ Initial
I do ____do not_____ specifically consent to the transmission of my medical records via a fax machine

Initial in the spaces provided:

- _____I recognize that the information disclosed may contain drug/alcohol information that is protected by federal and state law. I specifically consent to disclosure of such information.
- _____I recognize that the information disclosed may contain mental health information that is protected by federal and state law. I specifically consent to disclosure of such information.
- _____I recognize that the information may contain information regarding sexually transmitted diseases or HIV/AIDS testing information. I consent to the disclosure of such information.

_____ _____ _____
Signature of Patient or Representative Relationship (if signed by representative) Date Signed: