AUTHORIZATION TO RELEASE MEDICAL RECORDS

Regarding Patient: _____ **DOB:**_____

I request and authorize that you release a copy of the following medical records to:

To: Provider/Group/Facility: _____

Address: _____

Telephone #: _____ Fax #: _____

- ❑ Complete Medical Record
- ❑ Biopsy Report(s)
- ❑ Lab Report(s)
- ❑ Consultation Reports
- ❑ Medication Allergies
- ❑ Allergy Test/Treatment
- ❑ Surgical Procedures
- ❑ Other _____

Please check one:

- ❑ For dates of service from ___/___/___ to ___/___/___
- ❑ For all dates of service

Additional Comments:

_____
_____
_____
_____

I understand that there may be a reasonable medical records copying fee as permissible by state law.

_____ ___/___/___
Patient/Guardian Signature Date

_____
Relationship (if not patient)