Records Release Authorization

Use this form to request release or transfer of medical records. Contact the office for secure submission instructions and any records-processing requirements.

PATIENT

Patient Name

Date of Birth

Phone

Email

RELEASE FROM

Provider / Facility Name

Phone

Fax

Address

RELEASE TO

Provider / Facility Name

Phone

Fax

Address

RECORDS REQUESTED

- [ ] Medication list
- [ ] Office visit notes
- [ ] Lab results
- [ ] Problem list
- [ ] Hospital reports
- [ ] Complete medical record

Date range

Purpose of request

Special instructions

Patient / Representative Signature

Date

Printed Name and Relationship if not patient