Focused Life
CLINIC

Medical Record Release Form

By signing this form, I authorize Focused Life Clinic to release or obtain my protected and confidential health information. They may do this by releasing or obtaining a copy of my medical records or a summary or narrative of my protected and confidential health information to/from the person(s), provider(s), entities or facility listed below.

Patient Name:____________________________________ Date of Birth: ______/_______/_______

Address: ____ City:_____________________ State:________

Zip: ____________ Phone: (___)_________________ Email: _____________________________________

INFORMATION REQUESTED FROM

Name (Provider, facility, entity):____

Address: ___________________________ City: _____________________ State: ______ Zip: __________

Phone: (____)_____________________ Fax: (____)________________________

SEND INFORMATION TO

Name (Provider, facility, entity): ____

Address: ___________________________ City: _____________________ State: ______ Zip: __________

Phone: (____)_____________________ Fax: (____)________________________

Send by:

☐ Fax ☐ Mail ☐ E -mail:________________

Effective Period: This authorization for release of information covers the period of healthcare from ________________ to __________________ or for the duration of one year from date signed unless I revoke the authorization in writing.

The Information that you may release/obtain subject to this signed release form is as follows:

☐ Complete record
☐ Mental Health /Substance abuse
☐ Labs results
☐ Imaging/testing reports & results
☐ Medication Record
☐ Progress notes
☐ History & Physical
☐ Other (please specify below)
☐ HIV/AIDS

____ ________________________

Printed Name Patient/Legal Guardian Date

______________________________________ ________________________

Patient/Legal Guardian signature Date