MEDICAL RECORD RELEASE AUTHORIZATION FORM

Patient Information

Full Name: _____ Date of Birth:_____
Address: _____
City _____ State _____ Zip Code:_____
Phone Number: _____ Email Address: _____

Release Information

I authorize the release of my medical records to: (if none, please enter n/a)
Recipient Name: _____
Recipient Address: _____
Phone Number: _____ Fax or Email: _____

Information to Be Released

□ Complete medical record □ Dental history □ Treatment Needs □ Imaging
□ Medications □ Treatment records □ Other: _____

Purpose of Release

□ Personal use □ Continued medical care □ Legal reasons
□ Insurance □ Disability determination □ Other:_____

Authorization and Expiration

This authorization will expire on (date): _____
If no date is specified, this authorization will expire one year from the date of signature.

Patient Rights

I understand that:

I have the right to revoke this authorization at any time by submitting a written request to the provider listed above.

Revocation will not affect any information already released in response to this authorization.

Patient Signature:_____ **Date:** _____