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RECORDS RELEASE FORM

Patient Name:_____ Date of birth:_____

Home Phone:_____ Cell phone:_____

Address:_____ City/State/Zip:_____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Release From:_____ Phone:_____

Address:_____ Fax:_____

City/state/zip:_____

Information to disclose:
- ❍ **2 years prior to last seen**
- ❍ **Other dates_____**
- ❍ **Specific information requested:**

_____

_____

Purpose of disclosure:
- ❍ **Change of physcian**
- ❍ **Continuation of care**
- ❍ **Other_____**

This information may be disclosed and used by the following individual or organization:

Release To:_____ Phone:_____

Address:_____ Fax:_____

City/state/zip:_____

Signature:_____ **Date:**_____