# Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:_____ Date of Birth:_____

Primary Physician's Name: _____

Physician's Phone#: _____

Physician's Fax#: _____

**The information you may release subject to this signed release form is as follows**:

- ☐ Complete Records
- ☐ Care Plan
- ☐ Pathology Reports
- ☐ Hospital Reports
- ☐ History of Physical
- ☐ Lab Reports
- ☐ Treatment Records
- ☐ Medication Record
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Others (Please Specify):_____ _____ _____

**Release my protected health information to the following Physician/person/facility/entity/and/or those directly associated in my medical care:**

Name: Novak Clinical Research

Email: Novakclinicalresearch@gmail.com Phone #: (520)-909-2622 Fax #: (520)-909-0384

Address: 7482 N La Cholla Blvd. City: Tucson State: AZ Zip Code: 85741

**The purpose/reason for this release of information is as follows:**

_____

_____

**Signatures:**

_____
Patient's OR Patient's legal guardian/parent Signature

_____
Date