

**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:

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

* History&Physical
* Care Plan
* Lab Reports
* Pathology reports
* Treatment Record
* Medication List
* Progress Notes
* Radiology Reports
* Operative Reports
* Complete Record
* Hospital reports
* Other

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

Name: Address: City, State, Zip**:**

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