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Authorization for release of medical information

Patient's Name: ______________________________ DOB: ____________________

Requester's Name and Phone #: ____

I hereby authorize and request copies of medical records from:

______________________________ ____________________
(Name of Company/Agency/Facility/Person) (Phone #)

______________________________ ____________________
(Street Address, City, State, Zip) (Fax #)

Information to be released to:

______________________________ ____________________
(Name of Company/Agency/Facility/Person) (Phone #)

______________________________ ____________________
(Street Address, City, State, Zip) (Fax #)

Check Information to be Requested:

- ☐ Entire Record
- ☐ Immunization Records
- ☐ TB Skin Test
- ☐ Lab Tests
- ☐ X-Ray Reports
- ☐ Physical Exams
- ☐ Discharge Reports
- ☐ Billing Records
- ☐ Other (specify):____________________

Reason for Request:

- ☐ Change of Doctor
- ☐ Continuation of Care
- ☐ Personal Records
- ☐ Attorney/Legal
- ☐ Insurance
- ☐ Consultation
- ☐ Other (specify):____________________

I would like to this information to be:

- ☐ Mailed
- ☐ Pick Up
- ☐ Faxed (Only shot records can be faxed)

I understand this information is confidential and there shall be no further disclosure without the written authorization of the patient and his/her legal guardian. Multiple requests may necessitate a copying fee of $25.00. Please be aware that by state law we have 14 days in which to comply with your request. (Shot records can usually be faxed the same day.)

______________________________ ______________________________ ____________________
Signature of Parent/Legal Guardian Relationship to Patient Date