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MEDICAL RECORDS RELEASE

To: (Practice/Doctor Name: _____
Practice Street Address: _____
Practice City, State, Zip: _____
Practice Fax Number: _____

Re: _____

This letter will authorize you to provide a copy, summary, or narrative of _____'s medical records or to otherwise release confidential information.
(Patients Name)

At this time I am requesting the following:

_____ Complete record (including but not limited to: lab results, consultation notes, etc.)

_____ Records of care from _____ to _____ only.

Send to: _____ **Send Via:** (Circle One) US POST MAIL FAX EMAIL

Name () **Tel #:** () **Fax: #**

Street **City** **State** **ZIP**

Email Address

- OR -

_____ Confer with other person orally about information in my medical record, to the following person(s):

Name () **Tel #**

Name () **Tel #**



The reasons or purposes for this release of information are:

I understand that you will provide this information within 10 business days from receipt of request, and you may charge a fee of a dollar per page, plus postage, if being sent via U.S. Post Mail, for preparing and furnishing this information. I also understand that I may revoke this consent at any time, by providing written consent to you.

Signed: _____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)