

Medical Records Release

(Name of Patient)

(Birthdate)

(Street Address)

(City, State, ZIP Code)

Authorizes:

Release of Records to:

(Name of Physician)

(Name of Physician)

(Name of Health Care Facility)

(Name of Health Care Facility)

(Street Address)

(Street Address)

(City, State, ZIP Code)

(City, State, ZIP Code)

Information to be Released:

- | | | |
|---|--|---|
| <input type="checkbox"/> All Clinic Records | <input type="checkbox"/> Visual Fields | <input type="checkbox"/> Allergy Records |
| <input type="checkbox"/> Eye Records | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Electrocardiograms |
| <input type="checkbox"/> Photographs | <input type="checkbox"/> X-Ray Films (Specify) | <input type="checkbox"/> Other (Specify) |

List other facilities records to be included when releasing for the purpose of continuing medical care:

For the Following Dates: _____

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Mental health | <input type="checkbox"/> AIDS test results | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Developmental disabilities | <input type="checkbox"/> AIDS-related disease diagnosis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Alcoholism | | |

Purpose or need for disclosure: (check applicable categories)

- | | | |
|--|---|--|
| <input type="checkbox"/> Further medical care | <input type="checkbox"/> Payment of insurance claim | <input type="checkbox"/> Legal investigation |
| <input type="checkbox"/> Application for insurance | <input type="checkbox"/> Vocational rehabilitation evaluation | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Disability determination | | <input type="checkbox"/> Other |

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records. _____

(Alternate date if not one year)

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

Signature of Patient _____

Date _____

(If signed by person other than patient, state relationship and authorization to do so)

(Authorized signature)

(Relationship)

Patient is: Minor Incompetent Disabled Deceased

Legal Authority: Legal Legal guardian Next of kin of deceased