Authorization of Medical Release

Date ______________________________

Patient Name ______________________________ Date of Birth___________________

Last 4 Digits of **SSN#** __________

I am a current/ former patient of _____________________________________

Phone number __________________ Fax ___________________

I authorize and request that you send a copy of my medical records to:

Name :

Address:

City, State, Zip:

Phone number:

E-mail:

Records you would like sent:

I Authorize my records to be sent via (choose one): ☐ **Email** ☐ **Mail** ☐ **Fax**

This clinical information will be regarded as confidential and privileged and will be used solely for patient management.

Patient_________________________________
Signature

Patient _________________________________
Print Name

Please be advised that records requests have a turn-around time of up to 2 weeks.

Charges for records requests are as follows: **Please see next page.**

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