AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM.

I, _____, hereby voluntarily authorize the disclosure of information from my health record.
(Name of Parent)

Patient Information:

Patient Name: _____

Address: _____ Date of Birth: _____

Records Requested (PLEASE CIRCLE): **Full Chart** **X-rays**

Purpose of Release (PLEASE CIRCLE): **Moving** **2nd Opinion** **Changing Providers** **Personal**

The Information Is to Be Provided To:

Name of Person/Facility/Office: _____

Mailing address: _____

Phone Number: _____

Email (PREFERRED): _____

Records to be sent via (please circle): **Secured Email** **FAX** **Mailing Address**

_____ _____
Parent's Signature or Patient's Representative Date

_____ _____
Printed Name of Parent / Patient's Representative Relationship to Patient

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS.

Under HIPAA with a patient's written request, records must be provided within 30 days of a request.
HIPAA Authorization for Release of Medical Records
This form does not constitute legal advice and covers federal, not state law

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