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Authorization for Release of Medical Records

Patient Information Name: (Last) (First) (M) Date of Birth: Social Security Number: **Request Release from:** Doctor/Facility/Hospital: Address: Phone: _____ Fax: _____ I hereby authorize you to release to ______ a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Further, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, no longer protected under privacy rules. Patient or Guarantor Signature **Please include the FOLLOWING ITEMS:** Admission notes Progress notes ____Discharge summary Pathology reports Consultations notes Operative reports ___EKG'S Laboratory tests Stress Tests X-ray reports Other Remarks: