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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

Patient Name: _____ DOB: _____

SS# _____

Purpose / need for information

- Application for Insurance
- Changing Physicians
- Personal
- Regarding Insurance Claim
- Specialist

SPECIFIC RECORDS REQUIRED:

- Office Notes:
- Laboratory Reports
- X-ray reports _____

(Specify if necessary)

OTHER:

- _____
- _____
- _____

Records Requested From:

Records Sent To:

This information, including diagnosis and records of any evaluation, examination and/or treatment rendered to me during the period:

FROM: _____ **TO:** _____

I understand that this information will expire 90 days from the date of signature below or when acted upon, whichever event occurs first, I hereby release the following addressee, its employees and appointed representatives from any and all liability that may arise from the release of information as I have directed.

Signature of Patient/Guardian