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INTENDED ENTITY
Physician/Facility/Person:
Address:

Phone:

MEDICAL RECORDS RELEASE

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary of a narrative of my protected health information to the physician/person/facility/entity listed below.

Today's Date_____

Patient name_____ Patient date of birth_____

THE INFORMATION YOU MAY RELEASE SUBJECT TO THIS SIGNED RELEASE FORM IS CHECKED BELOW:

☐ Complete Records ☐ History and Physical ☐ Progress Notes * ☐ Other*

☐ Medication & Allergy Records ☐ Treatment Plan* ☐ Surgical History ☐ Glasses/CL Rx*

*_____
_____
_____
_____

Release my protected health information to the following person/physician/facility:

Name:_____

Address:_____

Phone:_____

**Providers have 15 business days to comply with written records requests.*

THE PURPOSE OF THIS RELEASE IS *(check one or more)*

☐ Continuity of care

☐ Patient requested

☐ Other (Specify reason)_____

_____ _____

(Signature of Patient or Patient's Legal Representative) Date

_____

Printed Name

_____

(If signed by someone other than the patient, state your legal Relationship to the patient/authority)

FOR INTERNAL USE ONLY

Date sent:	
VIA:	
IN:	