

Request for Records Release

Physicians name _____
Street address _____
City _____ State _____ Zip _____

Dear Doctor _____:

The following individual has asked us to request that his or her medical records be released and forwarded to our office:

Patient name _____
Birth date _____ Social Security # _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file. Please to be sure to include:

- _____ Progress notes
- _____ Consultation Reports
- _____ Laboratory Results
- _____ X-Ray films and reports
- _____ All Records
- _____ Discharge summaries from my hospitalization of _____
- _____ Other

Thank you for expediting this request. Please send these records to our office address shown above.

I hereby authorize the release of all necessary medical records to _____ . I wish for them to be forwarded as soon as possible.

I understand that I may revoke this authorization, at any time, in writing, except to the extent that my provider or the provider's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Patients signature _____
(or parent if patient is a minor)
Patients address _____ City _____ State _____ Zip _____
Signature of witness _____