Request to Send Records Release

Patient Name ______________________ Birthdate __________________________

Social Security# ____________________

Dear ____________________________,

The following patient has asked us to release and forward her medical records to your office:

Physician's Name ____________________________ Phone # ____________________________

Mailing Address

____

City ________________________________ State ________________ Zip ________________

☐_**All PHI in the record**	☐**Lab Test**	☐**Image Reports**	☐**Operative Reports**
☐**Progress Notes**	☐**Discharge Summary**	☐**History and Physical Examination**	
☐**Pathology Results**			
☐**Other**			

Selecting all PHI is authorization of STD results, testing, whether negative or positive. In addition, this is authorization regarding drug, alcohol, or mental health treatment.

I hereby authorize the release of all necessary medical records to

Patient's Signature ______________________________________ **Date** ___________________
(or parent if patient is a minor)

Witness's Signature ______________________________________ **Date**___________________

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