Request for Records Release

Patient Name: _____

Birthdate: _____

Social Security No.: _____

Dear _____,

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

Physician's Name:_____Phone No.: _____

Mailing Address: _____

City: _____ State: _____Zip Code: _____

__All PHI in the record	**__Lab Tests**	**__Imaging 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)

Signature of Witness: _____

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