Patient medical records release form

This form is to be used to obtain a copy of your chart for yourself or to have medical records transferred or sent to another physician. **Please allow 7-10 business days for processing.**

Patient's Name _____ Patient's D.O.B: _____

Patient's address:_____

Todays Date _____
If requesting on behalf of a patient Name of requestor and relationship to Patient:
_____

By signing this form, I authorize you to release confidential health information about _____ (Patient name), including a full copy of the patient's medical records, or a full summary/narrative of the patient's protected health information, to the person(s) or entity listed below.

Limitations on the information you may release subjected to this release are as follows:

_____

Release protected health information to the following person(s)/entity:
(If you are the patient and are releasing these records to yourself only, then please write your name and address below.)

_____
Your Name or your new Doctor's name:

_____
Street:

City: _____ State: _____

Zip:_____ FX #_____ Ph#_____

If you are picking up in person please sign and date below

_____
Patient name/patient representative if under 18 *Patient signature* *Date*

_____
Driver's license or State ID number

_____
Staff initials and date of record pick up