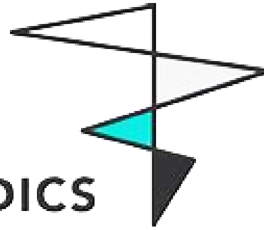

Authorization for Release of Medical Records

I authorize ____

(Entity)

to disclose information from the medical records of ____ ___________________

(Patient Name) (DOB)

to____

____

____.

Purpose of disclosure:____

I give permission for the following information to be released:

_____ Entire medical record

_____ All progress notes

_____ Statement/Billing information

_____ Records for dates of treatment ___________________ to ________________________________

_____ Other: ____

I give permission for the above information to be released by the means of:

_____ Writing/photo copy/paper

_____ Email

_____ Verbally

_____ Fax

____ _____________________

Signature of Patient/Legal Guardian Date