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MEDICAL RECORDS REQUEST
AUTHORIZATION TO REQUEST A COPY OF MEDICAL RECORDS TO BE FORWARDED

Please print this page, read it carefully, fill it in, and sign it. Then fax, mail, or hand-deliver to the address in Step 2. *This only allows a copy of your medical records to be forwarded to this office. It does not affect your relationship with this physician.*

STEP 1- PATIENT INFORMATION

Name_____ Date of Birth _____

Social Security #: _____ Phone #: _____

Address _____

STEP 2 – CURRENT LOCATION OF RECORDS THAT YOU WANT COPIED

Name of Practice/Hospital/Doctor _____

Address _____

Telephone: _____ and/or Fax: _____

STEP 3- INFORMATION YOU WANT COPIED AND RELEASED

□ All records *or* □ Dates of treatment: _____ to _____
□ Labs □ Radiology reports □ Radiology films (specify) _____

STEP 4- LOCATION TO WHICH YOUR RECORDS SHOULD BE SENT

Name of Practice/Hospital/Doctor _____

Address _____

Telephone: _____ and/or Fax: _____

This authorization is valid for ninety (90) days and may be revoked in writing at any time prior to the expiration date.

Patient Signature _____ Date _____

Release of Sensitive Information: I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric issues, sexually transmitted diseases, social service, hepatitis testing/treatment, HIV testing/treatment and/or sensitive information, I agree to its release.

Patient Signature _____ Date: _____