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**MEDICAL RECORDS RELEASE**

TO: ________________________________________________________________________________

________________________________________________________________________________

(Name and address of physician/clinic sending medical records)

**Scope of Request:**

_______ I would like a copy of my records sent to the following physician/medical facility:

Doctor's name (who records should be sent to) ___________________________________
Clinic name………………………………………………… ___________________________________
Clinic's phone number………………………………….. ___________________________________
Clinic's fax number……………………………………….. ___________________________________
Clinic's address……………………………………………. ___________________________________
___________________________________

_______ I would like to obtain a copy of my records (fee may apply)

**Description of Records Requested:**
*(Please describe the records or types of records requested. Please also let us know how far back in time you want access to records.)*

____________________________________________________________________________________
____________________________________________________________________________________

**Patient Name (printed):**_______________________________________ Date of birth________________

**Patient Address:**__________________________________________________________________________

**Telephone Numbers:**_______________________________________________________________________

**Authorization:**

Signature of Patient: _____________________________________________ Date:__________________

**Representative of patient:**

Personal Representative of Patient/Parent or Guardian Name:_______________________________________

Describe Relationship of Personal Representative:______________________________________________

*I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.*

Signature of Representative/Parent or Guardian:_________________________________Date:___________

Witness:_________________________________________________________________Date:___________