

# Medical Records Release Authorization Form

Authorize the release or transfer of health information in accordance with HIPAA regulations. Complete all required sections to process your request.

## Patient Information

Please provide the patient's details as they appear on medical records.

**Full Name \***

**Date of Birth (MM/DD/YYYY) \***

**Phone Number \***

**Email Address \***

**Address (Street, City, State, ZIP) \***

**Person Requesting Records \***

- Self (Patient)  
 Authorized Representative

**If you are an authorized representative, please provide your full name. \***

**Relationship to Patient \***

**Legal Authority to Act (e.g., parent, guardian, power of attorney) \***

**Facility or Provider Releasing Records (Name, Address, Phone/Fax) \***

**Recipient of Records (Name, Address, Phone/Fax/Email) \***

**Type of Records Requested (Check all that apply) \***

- Complete Medical Record
- Immunization Records
- Lab Results
- Radiology/Imaging Reports
- Visit/Progress Notes
- Billing Records
- Dental Records
- Physical Therapy Records
- Veterinary Records
- Other

**If 'Other', please specify the records requested:**

**Purpose of Release \***

- Continuing Care
- Insurance
- Legal
- Personal
- Other

**If 'Other', please specify the purpose:**

**Sensitive Information Disclosure (Check all that apply)**

- HIV/AIDS-related information
- Mental/Behavioral Health
- Substance Use Disorder
- Genetic Testing
- None of the above

**I acknowledge that by checking the boxes above, I am authorizing the release of any selected sensitive information. \***

I acknowledge and authorize the release of selected sensitive information.

**Format of Records Requested \***

- Paper Copies
- Electronic (PDF)
- Electronic (CD/USB)

**Delivery Instructions (e.g., mailing address, email, fax, pickup instructions)**

**Expiration of Authorization \***

- 12 months from date of signature
- 6 months from date of signature
- One-time use only
- Other (specify date below)

**If 'Other', please specify expiration date (MM/DD/YYYY):**

**Patient Rights & Acknowledgment (Please read and check all that apply) \***

- I understand I may revoke this authorization at any time in writing, except to the extent that action has already been taken.
- I understand that authorizing the disclosure of this information is voluntary.
- I understand that information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
- I have read and understand this authorization.

**Signature Section**

The person signing below certifies that they have the legal authority to request the release of these records.

**Name of Person Signing \***

**Relationship to Patient (if not patient)**

**Signature (Type your full name as your signature) \***

**Date Signed (MM/DD/YYYY) \***

**Witness Name (optional)**