**PLEASE ALLOW 10-14 DAYS FOR RECORDS TO BE PROCESSED/COPIED**

Date Received: _____
Employee's Initial: _____

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# Medical Records Release/Request

Patient's Last Name: _____ First Name: _____ Middle Name: _____ Date of Birth: _____
Social Security #: _____ Home Telephone: _____ Cell Phone: _____
Address: _____ City: _____ State: _____ Zip Code: _____

**The records or information I wish to be sent or received are:** (check all that apply)

☐ EKG REPORTS ☐ PROGRESS NOTES ☐ PHYSICAL ☐ LAB REPORTS
☐ OTHERS (please specify): _____

**Covering the period from _____** (date) **to _____** (date)

**The reason I want these records or information transferred is:**

☐ for medical care ☐ to go to an attorney ☐ to go to my insurance company ☐ others: _____

- This authorization is valid for a period of 120 days from the date of the signature below, and can be revoked/cancelled in writing at any time prior to the expiration date
- The patient agrees that a copy of this authorization may be considered valid: Yes ____ No_____
- Are you transferring your care to another physician? Yes ____ No _____
  If so, please explain why: _____

☐ **I will pick up the copies of my records** ☐ **Fax the copies of my records** ☐ **Mail copies of my records (subject to registered mailing fee)**

| RECORDS FROM: | RECORDS TO: |
|---|---|
| **NAME:** | **NAME:** |
| **ADDRESS:** | **ADDRESS:** |
| **PHONE:** | **PHONE:** |
| **FAX:** | **FAX:** |

**Patient's Signature Authorizing Request/Release of Records:**

**Signature: _____ Date: _____**

**Physician's Signature Authorizing Release/Request of Records:**

**Signature: _____ Date: _____**