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Authorization for Release of Medical Records

Patient Information:	**Request Release Forms:**

Date of Birth: _____ Social Security #:_____

I hereby authorize you to release to _____ a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Further, I understand that this Protected Health Information (PHI) may be re-disclosed by the recipient and thus, no longer protected under privacy rules.

_____ _____
Patient or Guarantor Signature Date

Please include the following items:

_____ Admission notes
_____ Progress notes
_____ Discharge summary
_____ Pathology reports
_____ Operative notes
_____ Consultation notes
_____ Laboratory tests
_____ Medications

Remarks:

This authorization will expire on:
