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**AUTHORIZATION AND REQUEST FOR RELEASE OF MEDICAL RECORDS**  
**A MINIMUM OF 72 HOURS ADVANCE NOTICE REQUIRED TO PROCESS THE REQUEST**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Current Address: \_\_\_\_\_

Home#: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

**Reason for Request:**

- Selected New Physician in the Area       Second Opinion Consult       Change of Insurance  
 Moving out of town       Other: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize you to furnish to: \_\_\_\_\_

By Method of: (Please Check One)      FAX: \_\_\_\_\_      MAIL: \_\_\_\_\_      PATIENT WILL PICK UP RECORDS: \_\_\_\_\_

Recipients Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Portion of Records to be Released:**     Entire Medical Record    **OR**     Other (please specify) \_\_\_\_\_

I understand these records may contain information from other health care providers, as well as information that is administrative in nature. I specifically consent to the release of any information contained in the medical record that may relate to infection with Human Immunodeficiency Virus (HIV), AIDS or related conditions.

I understand that you have no responsibility for the use of distribution of this information by the party to whom it is released. I release you from all liability that may arise from your compliance with this request to release records.

I authorize you to transmit this information by facsimile (fax) transmission, if I so desire, and release you from any liability for breach of confidentiality, misdirection of transmission or failure to receive transmission if my records are transmitted by fax.

\_\_\_\_\_  
Patient/Legal Representative Signature      Date

Patient unable to sign because \_\_\_\_\_

Relationship of Legal Representative: \_\_\_\_\_

*Revised 07-18-2018*