

**Records Request Authorization**

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

**CONSENT FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_ authorize \_\_\_\_\_  
(Name and/or facility)

\_\_\_\_\_  
(Address, City, State, Zip) (Phone and Fax Number)

to disclose the following healthcare information for treatment on these dates \_\_\_\_\_.

The information released will be used for the following purpose:  
\_\_\_\_\_.

I specifically authorize the following for release:

- Entire record                       Only those items listed below:
- Visit/Progress Notes
- X-ray / MRI Reports
- X-ray Films
- Range of Motion
- Lab Results
- Other \_\_\_\_\_

I authorize disclosure of the above mentioned medical records for the purposes stated above. I also am aware that I am not giving permission for any disclosure other than what is described above. I understand that I can revoke this authorization at any time, except to the extent actions have already taken place.

This release is effective for 90 days from the date signed unless other specifications follow:  
\_\_\_\_\_

I understand that the parties in receipt of my healthcare information may not further disclose my information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date