

Medical Records Release

To: _____

Name

Fax Number

I, _____ request a copy of the following medical records:

- Complete Medical Record
- Biopsy Report(s)
- Lab Report(s)
- Other _____

To be released to:

Name

Address

City, State, Zip

Fax Number

Phone Number

By signing below, I authorize the above named physician(s) or any of the staff to disclose, reveal, or open for inspection or observation, any report, statement, analysis, diagnosis or any professional record including mental, psychiatric, alcohol and drug abuse records and HIV records. I hereby waive and release the above named physician(s) or any of the staff from any restrictions imposed by law, in disclosing or revealing any professional record, observation, or communication to the person(s) name.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____