



Consent and Authorization for Release of Records

Patient Name(s) and DOB: _____

Phone Number: _____ Date of Request: _____

I authorize: _____
(Office Name)

(Address)

(Phone Number)

(Fax Number)

To release the following medical record documents (please indicate by circling):

- ☐ All Records
- ☐ Immunization Records
- ☐ Other

(describe) _____

*Only medical records originated through this healthcare facility will be released. There will be a \$25 administrative fee for complete charts.

Understand the information in the requested health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and substance abuse.

To the following: _____
(Office Name)

(Address)

(Phone Number)

(Fax Number)

The purpose of this request is (please circle one):

- ☐ **Change of Insurance**
- ☐ **Change of Physician**
- ☐ **Continuation of Care**
- ☐ **Other:** _____

Patient/Parent/Legal Guardian

Relationship to Patient

Signature/Date

Witness