Authorization for Release of Medical Records

Re: _____
Patient Name

This document or photocopy thereof will authorize you to provide orally or in writing, or by photostat or otherwise as requested, all information regarding my condition while under your observation or treatment.

This authorization includes, but is not limited to, all records, reports, memoranda, notes, telephone messages, correspondence, and any written documents, including but not limited to histories, findings, prognosis, consent forms, inpatient/outpatient records, doctors' orders and notes, progress notes, an x-ray reports, diagnosis, physical exam records, special reports, operative records, consultation records, medication and/or prescription records, diet records, and activity records, emergency room reports, and all other records and reports in my clinical chart pertaining to the aforesaid care and treatment. This also includes any and all financial records, including but not limited to billing records, statements for services rendered and insurance records.

This authorization revokes any prior authorizations that I may have signed and remains valid until revoked by me in writing.

Records to be released to:

Name: _____

Address: _____

City/State/ZIP: _____

Date of Birth: _____

Social Security Number: _____

Signature: _____ Date: _____