Medical Record Release Consent Form

Date: ____________________

Patient Information

Name: _____________________________________

Date of Birth: _____________________________

Address: __________________________________

City: ___________ State: _______ Zip: ________

Phone Number: ______________________________

Recipient Information

Name/Organization: _________________________

Address: __________________________________

City: ___________ State: _______ Zip: ________

Phone Number: ______________________________

Release Information

I hereby authorize the release of my medical records as follows:

- All medical records
- Specific records (please specify): _______________

Purpose of Release

The purpose of this release is: _______________________

Signature

Patient Signature: ____________________________

Date: _____________________________________

Witness Signature

Witness Name: ______________________________

Signature: _________________________________

Date: _____________________________________

Revocation of Consent

This consent may be revoked in writing at any time, except to the extent that the action has already been taken based on the consent.

If you have any questions, please contact us at: ______________________.