STONE RUN
FAMILY MEDICINE

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Date:_____

Request for Release of Medical Records

1 Patient Information:

Name: _____

DOB: _____ SSN: ****-**-_____

2 I request that the following medical records be released (check one):

_____**TO** _____ **FROM**

_____
Doctor/Facility Name

_____
Address City State Zip

_____
Phone Fax

3 Purpose of Disclosure:

- ☐ Changing Physicians
- ☐ Legal
- ☐ Continuing Care/Specialist Appointment
- ☐ Workers Comp
- ☐ Other (Please specify: _____)

4 Dates Requested:

_____ to _____

_____ All past dates

_____ Other (Please specify: _____)

I understand that this authorization will be valid for one year. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that if my record contains information related to substance abuse, HIV related information, and/or mental health information, that information will be released with my medical record.

5

_____ _____

Signature of Patient/Legal Guardian/Personal Representative **Date**

If signed by anyone other than the patient, state the relationship and/or reason and legal authority to do so: