Medical Records Release Form

Patient Name____ Medical Record Number____________________

Address/Street Number ____

City, State and Zip Code ________________________________ Phone___________________________

Date of Birth ______________________Social Security Number/*last for only* XXX-XX- ____________________

Records To Be Released or Disclosed To

Name of Person or Facility ____

Address/Street Number ____

City, State and Zip Code _______________________________ Phone ____________________________

Email ____ Fax ______________________________

Please select all of the specific documents that apply to your request:

☐ Radiology Reports ☐ EKG, EEG, EMG ☐ Inpatient Record

☐ Lab Reports ☐ Emergency Room Record ☐ Other _____________

☐ Pathology Reports ☐ Outpatient Record

Please place your initials beside the options below to authorize the release of sensitive information pertaining to:

Mental Health _____ Drugs or Alcohol _____

Genetic Testing _____ HIV/AIDS/other infectious Diseases _____

Please select the purpose of your request:

☐ Continued Patient Care ☐ Personal ☐ Other _____________

☐ Worker's Compensation ☐ Insurance

☐ Attorney/Legal ☐ Social Service/Disability

Please select how you would like to receive your request:

☐ Mail to address above ☐ Pick up

☐ Email ☐ Fax to number above

I, ______________________________ (Name), do hereby consent and authorize Appling Healthcare to release copies of my medical records or other specified protected health information.

____________________________________ ____________________

Printed Name *Date*

____________________________________ ____________________

Signature *Date*