Release of Medical Information

# Permission to share my medical records

I, [patient’s name] , born on [patient’s date of birth] , give my permission for my doctor/hospital [name of doctor or hospital that has the records] to give the medical records (described on p. 2) to [doctor who needs the records] so that they can better understand my condition and help me.

# Permission to share sensitive information

You have my permission to share my records about topics below ONLY IF my initials are next to it.

 My mental health.

 Any disease I may have that others could get from me, like HIV or hepatitis.

 My genes.

 My use of drugs or alcohol.

# By signing below, I show that I understand:

* I do not have to share these records.
* The permission I am giving is good for only 3 months from the date I sign.
* If I want to stop sharing my medical records before then, I need to talk to the doctor’s office or hospital that has the records and find out what I need to do to stop the sharing.

Patient’s or Authorized Representative’s Signature Date

Relationship of Authorized Representative:

Consent for release of medical records for [patient’s name]

## The doctor who needs the records will fill out this page.

## Requesting records from:

Name of Practice:

Name of Physician:

Fax number/secure email address:

Address:

## Types of records we are requesting:

☐Any andall types of records you have for this patient

☐Doctor visit notes ☐Doctors orders

☐Emergency room notes ☐Nurses notes

☐Urgent care notes ☐Discharge summary

☐History and physical ☐Lab reports

☐Hospital progress notes ☐Radiology reports

☐Operation or procedure notes ☐Consultations

☐Clinic notes ☐Other

☐Pathology reports

## Records within the following dates:

☐All dates

☐Records dated between and

## Please send records to:

Attention:

At fax number: or secure email:

Or mail to:

**For any questions** please call (phone number):

and ask for: