RECORDS RELEASE FORM

FROM: _____

ADDRESS :_____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF **ONE COPY** OF MY MEDICAL RECORDS

TO: _____

ADDRESS: _____

This information has been released to you specifically with the consent of the patient or his/her authorized representative. It is strictly confidential and no further release or use of the information is authorized without the consent of the patient or authorized representative.

PATIENT NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____

SIGNATURE: _____ DATE: _____

Single Disclosure Continuing Disclosure for 90 days Expiration Date: _____

I hereby release the facility from any liability, which may arise as a result of the use of the information contained in the records released.