REQUEST TO RELEASE MEDICAL RECORDS

PATIENT'S FULL NAME: _____

INCIDENT DATE: _____

INCIDENT ADDRESS: _____

WHAT IS YOUR INTEREST IN THIS MEDICAL RECORD?_____

_____

If you are not the patient named on requested medical record you <u>must</u> have the release filled out below by either the patient or legal guardian.

RELEASE OF MY MEDICAL RECORDS TO:

NAME: _____

ORGANIZATION: _____

ADDRESS: _____ **STATE:** _____ **ZIP:** _____

PHONE #: _____ **FAX #:** _____

PATIENT or AUTHORIZED SIGNATURE:

_____

DATE SIGNED: _____

RELATIONSHIP TO PATIENT: _____

Patient is: ☐ **Minor** ☐ **Incompetent** ☐ **Disabled** ☐ **Deceased**
Legal Authority: ☐ **Legal** ☐ **Legal Guardian** ☐ **Next of Kin of Deceased**

Note to the recipient of medical records: The patient record is released to your custody only. Any further release of information to other recipient with out the written consent is strictly prohibited.

REQUESTER'S SIGNATURE: _____ **DATE:** _____