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MEDICAL RECORDS RELEASE

Patient Name_____
Last First MI
Date of Birth_____

I request and authorize the above physicians to:

<>OBTAIN my medical records from

<>RELEASE my medical records to

Specific requests:

<>ALL medical records
<>Labs and Path reports only
<>From dates _____to _____

I understand that all information obtained by the recipient will be held confidential in accordance with HIPPA privacy laws (copy of *Notice of Privacy Practices of Protected Health Information* available upon request). I may revoke this consent at any time.

Patient Signature_____Date_____