

AUTHORIZATION TO RELEASE MEDICAL RECORDS

TO: (Provider) _____
(Name of Doctor, Clinic, Hospital, etc.)

ADDRESS: _____

I, _____ request the following information:
(Patient's Name)

- X-Rays History Records Diagnosis
 Treatment Reports MRI/CT

Concerning my: Accident Injury Illness Other _____

To be released to: _____
(Name of Insurance Co., Attorney, Doctor, Hospital, Employer, Next of Kin, etc.)

Address: _____

For the purpose of: _____
(Specify: Review, Investigation or Evaluation, Application, The processing of any claim, or any purpose reasonably related to the above.)

I understand that I have a right to receive a copy of this authorization upon my request.

Copy requested Yes No Copy received Yes No

Signed: _____ Date _____

- Patient Spouse Parent Guardian Other