Consent and Authorization for Release of Medical Records

This **consent and authorization form** sample is designed to facilitate the release of medical records securely and efficiently. It ensures that patients provide clear permission for their health information to be shared with authorized parties. Using this form helps maintain compliance with privacy regulations and protects patient rights.

Patient Information

Full Name:

Date of Birth:

Address:

Phone Number:

Recipient Information

Name/Organization to Receive Records:

Address:

Phone Number (if applicable):

Authorization Details

Purpose of Disclosure:

Type of Records to be Released:

- [ ] Medical History
- [ ] Lab Results
- [ ] Imaging Reports
- [ ] All Medical Records

Records From (dates):

MM/DD/YYYY - MM/D

Patient Consent

I hereby authorize the release of my medical records as indicated above. I understand that this consent is voluntary and that I may revoke it at any time in writing, except to the extent that action has already been taken in reliance on this authorization. I also acknowledge that once my health information is disclosed, it may no longer be protected by federal privacy law.

Signature:

Date:

Submit

This form is provided as a sample only. Please consult with legal or healthcare professionals to ensure compliance with local laws and regulations.