Medical Records Information Request Form

Please complete all relevant sections to request access to medical records. All information will be handled in accordance with applicable privacy regulations.

Patient Information

Full Name:

Date of Birth:

Address:

Phone Number:

Requested Medical Records

Type(s) of Records Requested (e.g., lab results, discharge summaries):

Date Range (if applicable):

e.g., Jan 2023 - Dec 2023

Purpose of Request:

Recipient Information

Recipient Name or Organization:

Recipient Address:

Authorization

By signing below, I authorize the release of my medical records as specified above. I understand that this authorization is valid for one year unless otherwise revoked in writing.

Patient Signature: _____

Date: _____

If signed by other than patient, indicate relationship:

Submit Request