Medical Records Release Authorization Agreement Form

This **Medical Records Release Authorization Agreement Form** sample allows patients to grant permission for their health information to be shared with authorized parties. It ensures compliance with privacy laws by clearly specifying the scope and purpose of the information release. Using this form helps maintain confidentiality while facilitating the transfer of medical data.

Patient Information

Full Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Recipient Information

Recipient Name or Facility: _____

Recipient Address: _____

Authorization Details

Scope of Information to Release: All Medical Records

Purpose of Release: _____ Dates of Service (if applicable): _____

If specific records, list details: _____

Patient Authorization

By signing below, I authorize the release of my medical information as specified above. I understand that this authorization is voluntary and that I may revoke it in writing at any time.

Signature: _____

Date: _____

Submit

Note: This is a sample form for informational purposes only. Please consult your healthcare provider or legal advisor for forms that meet local regulations.