Medical Records Document Authorization Form Sample

The **medical records document authorization form** sample serves as a crucial legal instrument, enabling patients to grant permission for the release and sharing of their health information. This form ensures compliance with privacy laws and protects sensitive data during medical information transfers. Utilizing a standardized template enhances clarity and efficiency in managing patient records access.

Authorization for Release of Medical Records

Patient Information

Full Name:

Date of Birth:

Address:

Phone Number:

Recipient Information

Recipient/Organization Name:

Recipient Address:

Authorization Details

Type of Records to Release: e.g. All records, Lab resul

Purpose of Release: e.g. Continuity of care, Ins

Set Expiration Date

Authorization & Signature

I hereby authorize the release of my medical records as specified above. I understand that this authorization is voluntary and may be revoked in writing at any time, except to the extent that action has already been taken in reliance on this authorization.

Patient Signature:

Date:

Submit

Note: This is a sample template. Please consult your healthcare provider or legal advisor before use.