MEDICAL RECORDS REQUEST LETTER

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Healthcare Provider / Facility Name: _____

Address: _____

Phone Number: _____

Recipient Name (if different): _____

Recipient Address: _____

Recipient Phone Number: _____

Authorization and Request:

I hereby authorize the release of my complete medical records, including but not limited to history, examinations, test results, billing information, and other relevant health information, to the recipient named above. This authorization covers all records in the possession of the healthcare provider or facility specified herein. I understand that this information may include sensitive data protected under HIPAA and other applicable laws. This authorization is valid for the purpose of facilitating my medical care and/or for other lawful uses as permitted by United States federal and state laws.

Purpose of Disclosure:

The purpose of this disclosure is to allow the recipient to obtain medical information necessary for continued treatment, legal, insurance, or personal use, as applicable. Records may be used solely for the purpose stated and may not be further disclosed without my written consent unless permitted or required by law.

Expiration and Revocation:

This authorization shall remain in effect until revoked by me in writing. I understand that revocation will not affect any disclosures made prior to receipt of the revocation. I acknowledge that I have the right to inspect or copy the information to be disclosed, and I may refuse to sign this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this form unless allowed by law.

Acknowledgment and Signature:

By signing below, I confirm that I have read and understood this Medical Records Request Letter, and I authorize the release of my medical records as described herein. I also acknowledge that a copy of this authorization is as valid as the original.

Signature: _____

Printed Name: _____

Relationship to Patient (if signed by personal representative): _____

Date of Signature: _____

Patient / Authorized Signatory

Signature: _____

Date: _____

Witness (if required)

Signature: _____

Date: _____