THIS IS ONLY A SAMPLE!!! PLEASE WRITE YOUR OWN BASED ON THE SPECIFIC NEEDS/SITUATION OF YOUR PRACTICE.

Sample – Authorization to Release Medical Records

1, (PATIENT NAME), authorize any physician, nurse, or other health care professional who has attended me, or any hospital at which I have been confined to furnish to (PERSON RECEIVING RECORDS) or an authorized representative, any and all information that may be requested regarding my physical or mental condition and treatment rendered and, if necessary, to allow them or any physician appointed by them to examine any x-ray pictures taken of me or records regarding my physical or mental condition or treatment. In addition, I also authorize the release of psychiatric/psychotherapy records, mental health records, and drug and alcohol treatment records under the same terms and conditions.

A photocopy of this document may be used instead of the original.

Signature

Witness

Date