

1 PATIENT INFORMATION

Patient Name		Date of Birth		Phone	
Address		City		State	
Social Security # (if needed for record matching)		Preferred contact for questions about this request			

2 WHERE SHOULD THE RECORDS COME FROM AND GO TO?

RELEASE INFORMATION FROM

Provider / Facility	
Address	
City / State / Zip	
Phone	
Fax	

RELEASE INFORMATION TO

Provider / Facility	
Address	
City / State / Zip	
Phone	
Fax	

3 INFORMATION TO BE RELEASED

Check all that apply.

- | | | | |
|--|---|--|--|
| ☐ Entire Record | ☐ Progress Notes | ☐ Diagnostic Imaging | ☐ Immunizations |
| ☐ Family Planning | ☐ Dental Records | ☐ Mental Health Records | ☐ Lab Results |

Other (please specify)

I do NOT wish to release records containing information related to these specified conditions:

4 PURPOSE + DATE RANGE

Purpose of Disclosure			
Requested Dates		to	

If unspecified, records from the past 5 years will be released.

5 AUTHORIZATION + SIGNATURE

- I understand that I may revoke this authorization in writing at any time, except to the extent that information has already been disclosed in reliance on this authorization.
- This authorization is valid for 365 days from the date of my signature unless I specify an earlier expiration date below.
- A photocopy or faxed copy of this authorization may be treated as valid by all parties.
- Hometown Family Health and its representatives are released from liability for disclosure of the information specified above when made in accordance with this authorization and applicable privacy requirements.

Optional earlier expiration date

Patient / Legal Representative Signature

Printed Name **Date**

Relationship to Patient (if signed by representative)