



# Medical Records Release Form

Patient Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address / Street Number \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Social Security Number / Last 4 digits only XXX - XX- \_\_\_\_\_

## RECORDS REQUESTED FROM:

Name of Person or Facility \_\_\_\_\_

Practice Address / Street Number \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Fax \_\_\_\_\_

## RECORDS TO BE DISCLOSED TO:

Name of Person or Facility \_\_\_\_\_

Practice Address / Street Number \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Fax \_\_\_\_\_

## Please select all the specific documents that apply to your request:

- ☐ All Notes and Consults ☐ Lab Reports ☐ Pathology Reports  
☐ Hospital Records ☐ Radiology Reports ☐ Other \_\_\_\_\_

## Please select the purpose of your request:

- ☐ Continued Patient Care ☐ Attorney/Legal ☐ Insurance ☐ Social Service/Disability  
☐ Worker's Compensation ☐ Personal ☐ Other \_\_\_\_\_

## Please send the records via:

- ☐ Mail to address above ☐ URGENT: Fax to number listed above

I understand that I may revoke this authorization any time. I understand that revocation of this authorizations will not apply to information that has already been released and that I must revoke this authorization *in writing* to Frankenmuth Medical Associates. I understand that I may refuse to sign this authorization and that my treatment cannot be conditioned upon my authorization of this disclosure. Unless otherwise revoked, this authorization will expire 1 year from the date of signature. ***My signature below confirms that I have read and understand the information in this authorization form and authorize the release of my medical records.***

\_\_\_\_\_  
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Authorized Representative

\_\_\_\_\_  
Please explain Representative's authority to act on behalf of the Patient