

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient's Name: \_\_\_\_\_  
Last First Middle Initial

Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I request a copy of medical records from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

On the above named patient for the following reason(s):

- \_\_\_\_\_ Change in Primary Care Provider
- \_\_\_\_\_ Moving or Relocating to another area
- \_\_\_\_\_ Other: (please explain) \_\_\_\_\_

**From:** \_\_\_\_\_  
Name of Releasing Physician or Facility

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**To:** \_\_\_\_\_  
Physician, Facility, or Person receiving Records

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Authorized Representative Date

I hereby authorize the release of all medical records except notes forwarded by a mental health professional, such as a Psychiatrist, Psychologist, or a Licensed Professional Counselor. I hereby release BAPTIST PHYSICIAN NETWORK from liability associated with this release.

Please complete all fields on this form. Omitted information may cause a delay in your request. 01/16

