

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