



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

