Medical Records Release Form

By signing this form, I authorize you to request confidential health information about me, by requesting a copy of my medical records, or a summary or narrative of my protected health information, from the physician/person/facility/entity listed below.

Patient Name:_____________________________________ Date of Birth:______________________________

The information you may release subject to this signed release form is as follows:

- ○ Complete Records
- ○ Care Plan
- ○ Pathology Reports
- ○ History and Physical
- ○ Medication Record
- ○ Progress Notes
- ○ Radiology Reports
- ○ Other ____

Request my protected health information from the following physician/person/facility/entity and /or those directly associated in my medical care:

Name:____

Address:____

City State Zip:____

Phone Number:____

Reason for release of information is:

____

____

Patient Signature or Personal Representative Signature Date

____

Authority of Personal Representative

HouseCall Primary Care, PLLC
INSERT ADDRESS