

Authorization to Release Medical Records

I authorize the healthcare provider or facility named below to release the medical records described here to the recipient named below, in accordance with applicable patient-privacy law.

Patient Name *

Date of Birth

Releasing Provider / Facility Name *

Releasing Provider / Facility Address

Recipient Name / Organization *

Recipient Address / Fax / Secure Email

Records to Be Released

- ☐ Complete medical record
- ☐ Visit summaries / office notes
- ☐ Laboratory and test results
- ☐ Imaging reports (X-ray, MRI, CT, etc.)
- ☐ Billing records
- ☐ Mental health / psychiatric records (requires explicit authorization in most jurisdictions)
- ☐ Substance use treatment records (subject to additional federal protections, e.g. 42 CFR Part 2 in the U.S.)
- ☐ Other (describe below)

Other Records (if applicable)

Date Range of Records Requested

Purpose of Disclosure

This authorization expires one year from the date signed below, or on the earlier date stated here, unless revoked in writing before that date. I may revoke this authorization at any time, except to the extent action has already been taken in reliance on it.

Earlier Expiration Date (optional)

Patient / Legal Representative Signature (type full name)

Date

Template provided for general reference only and does not constitute legal advice. Laws vary by jurisdiction — have a qualified professional review this document before you sign or rely on it. This form must meet HIPAA (U.S.) or your jurisdiction's equivalent patient-privacy requirements to be valid — confirm with your compliance officer before use, especially for mental health or substance-use records, which often require separate, more specific authorization.