

**Authorization for Release of Medical Records**

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Chart # \_\_\_\_\_

**Medical Record Request (please check)**

Immunization form with growth chart

Medical Office Notes

Labs/Reports

All Medical Records

**Reason for requesting records (check one)**

Change in Insurance Coverage

Dissatisfied with Provider

Dissatisfied with Clinic Staff

Attorney

Change in Physician

Copy for personal records

Moving out of town

Other \_\_\_\_\_

**Send Records From:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Sent Records To:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Access, Release and Inspection of Medical Records**

1. You may have access to inspect the patient's health records before disclosure or release.
2. You may refuse to sign this authorization
3. We must provide you with a copy of the signed authorization.

I hereby request that my medical records be released to the party listed above. I understand that I may revoke this authorization at anytime, except to the extent that action has already been taken to comply with it.

<b>Medical Record fees:      \$ 20.00 pages 1-5    .50 &gt; 6 pages + postage</b>
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Authorized Person's Signature

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Relationship to Patient

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Date Signed

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LWP Staff Initials & Date Medical Records Released