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Record Release Authorization Request

To:

Name	Or Organization/Facility	Phone Number	Fax Number

Dear Sir o Madam:

I hereby authorize and request that you release my medical records to the above-mentioned facility.

Records to Release:

- Resents Office Visit Records
- Labs/Pathology Reports
- Radiology / EKG / ECHO / Stress Test Report
- Consultations Reports
- Hospital / Surgery / Procedure Records
- Other (Specified Below)

If Other Specify

_____

Including HIV / Aids Testing

Patient / Guardian Signature

_____

Relationship to Patient

_____

Date (Fecha)

____/____/____

Patient Signature

_____

Date (Fecha)

____/____/____