Authorization to Release Medical Records

I authorize the release of my complete medical record, including but not limited to physician notes, diagnoses, medications, laboratory results, imaging, and billing records, to myself (patient access). This authorization is voluntary and may be revoked in writing at any time except to the extent that action has already been taken. This authorization will expire 180 days from the date of signature.

Patient: John Smith

DOB: 2001-01-01 Email: john.smith@email.com

Phone: 555-555-5555