



## Medical Record Release of Information Form

<b>Patient</b>	<b>Patient's Name:</b> _____ <b>AKA or Maiden Name:</b> _____ <b>Date of Birth:</b> _____ <b>SSN:</b> _____
	<b>Email:</b> _____ <b>Phone Number:</b> _____
<b>Delivery</b>	<div> <b>Send Records To:</b> <input type="checkbox"/> Patient           <input type="checkbox"/> Doctor           <input type="checkbox"/> Third Party         </div> <div> <b>Delivery Method:</b> <input type="checkbox"/> Email           <input type="checkbox"/> Fax           <input type="checkbox"/> Mail         </div> <div> <b>Timeframe:</b> <input type="checkbox"/> 1-2 days           <input type="checkbox"/> 3-5 days         </div>
	<b>Recipient:</b> _____
	<b>Email:</b> _____ <b>Fax:</b> _____
	<b>Address:</b> _____
	<b>City:</b> _____ <b>State:</b> _____ <b>ZIP Code:</b> _____
<b>Records</b>	<b>Records From Date:</b> _____ <b>Records To Date:</b> _____
	<div> <b>Information Requested:</b> <input type="checkbox"/> Records           <input type="checkbox"/> Bills           <input type="checkbox"/> Continuing Care         </div> <div> <input type="checkbox"/> Films (Images)           <input type="checkbox"/> Disability Form           <input type="checkbox"/> Transfer Care         </div> <div> <input type="checkbox"/> Second Opinion           <input type="checkbox"/> Insurance Underwriting         </div>
	<div> <b>Reason for Release:</b> <input type="checkbox"/> Insurance Claim           <input type="checkbox"/> Undisclosed           <input type="checkbox"/> VRO           <input type="checkbox"/> Disability Form         </div>
	<b>Specific Information Requested:</b> _____
<b>Doctor</b>	<b>Doctor or facility you would like information from:</b> _____
	<b>Phone Number:</b> _____ <b>Fax:</b> _____
	<b>Address:</b> _____
	<b>City:</b> _____ <b>State:</b> _____ <b>ZIP Code:</b> _____
<b>Signature</b>	I, the requestor for this Medical Release of Information Form warrant the truthfulness of the information provided in this application.
	<b>Requestor</b> _____
	<b>Requestor's Email</b> _____
	<b>Driver's License / State ID</b> _____