Sound Medical
Family Practice

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Request to Release Medical Records

Authorization to Release Protected Health Information

Patient Name:____

Date of Birth:_______________ Last Four Digits of SS Number: _____________

☐ I hereby consent and authorize Sound Medical Family Practice to **release** copies of my medical records to the following:

Name of physician/provider/patient_______________________________________

Address: ___________________________________ City: ___________________

State: _____ Zip Code: ______ Phone: (   ) ___________ Fax: (   ) ___________

☐ I hereby **consent and request** copies of my medical records to be released to Sound Medical Family Practice from the following:

Name of physician/provider: ____

Address: ___________________________________ City: ___________________

State: _____ Zip Code: ______ Phone: (   ) ___________ Fax: (   ) ___________

☐ I am requesting specific medical records: **Last 2 years of progress notes and labs. All radiology and immunization reports.**

☐ **I am Requesting:**____

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I understand I may revoke this authorization at any time. I understand this authorization form and I authorize my records to be released. I understand this authorization may include sensitive information such as consent for release of alcohol, drug, psychiatric, psychological, and information related to HIV testing, AIDS, and communicable diseases. I agree that a copy of this release or fax of this release shall be as valid as the original release.

____ __________
Signature of patient or legal representative Date

____ __________
Witness Signature Date

We Specialize In You