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Lifeline
Family Health & Wellness

MEDICAL RECORDS RELEASE FORM

CONSENT

Patient Name: _____

Address: _____

Phone: _____ Date of Birth: _____

REQUESTED RECORDS

Name of Person or Facility: _____

Practice Address: _____

Phone: _____

Fax: _____

Please select all the records that apply to your request:

- ☐ Clinic Notes
- ☐ Progress Notes
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Radiology Reports
- ☐ Lab Reports
- ☐ Pathology Reports
- ☐ Urgent Care
- ☐ Operative Reports
- ☐ EKG, EEG, EMG
- ☐ Emergency Room
- ☐ Doctor Consults
- ☐ Physician Orders
- ☐ Medication Record
- ☐ Other: _____

Please select the reason for your request:

- ☐ Continued Patient Care
- ☐ Worker's Compensation
- ☐ Attorney / Legal
- ☐ Personal
- ☐ Insurance
- ☐ Other: _____
- ☐ Social Service / Disability

Please select how you would like to receive your request:

- ☐ Mail to Address
- ☐ Fax

Date: _____ **Signature:** _____

Print Name: _____