MEDICAL RECORDS RELEASE

Patient Last Name, First Name (Please Print) _____

Date of Birth (MM/DD/YYYY) _____

Patient Social Security Number (000-00-0000) _____

Patient Home / Cell Phone (000-000-0000) _____

Street Address _____ **Apt. Number** _____

City _____ **State** _____ **Zip** _____

Please Release Records to:

Name of Person _____ **Phone (000-000-0000)** _____ **Fax (000-000-0000)** _____

Business Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Organization / Company (If Applicable) _____ **Relation to Patient (If Applicable)** _____

Please Release Records From:

Name of Person, Company or Organization _____ **Phone (000-000-0000)** _____ **Fax (000-000-0000)** _____

Business Mailing Address _____ **City** _____ **State** _____ **Zip** _____

I authorize the release of copies of:

- ☐ The last two years of my medical records
- ☐ All medical records
- ☐ Only those records pertaining to (specify types and dates): _____

Patient Authorization:

I authorize Redirect Health to release the rcord described above.

I understand:

- ☐ I may revoke this authorization at any time by notifying Redirect Health in writing, except to the extent action has already been taken based on this authorization.
- ☐ Information released under this authorization may be redisclosed by the receipient and may no longer be protected by federal privacy laws.
- ☐ Signing this authorization is voluntary and is not required to receive treatment, payment, enrollment, or eligibility for benefits.

Signature of Patient or Responsible Party _____

Date _____