



Record Release Form

Patient's Name and DOB

Date Requested

Provider

Initials

Dates/date range requested:

X-RAYS _____

RADIOLOGY/ LAB REPORTS _____

OFFICE NOTES/OTHER _____

Method of Receipt: **encrypted email** **Non-encrypted email** **Mail** **Fax**

Email: _____ Address: _____ Fax #: _____

*If recipient is other than the patient,
please give name, relationship, and address of recipient: Recipient Name: _____
Recipient Relationship: _____

Patient's Signature: _____

Regardless of who picks up the requested information, we must have the PATIENT's signature either on this form or on a separate note requesting the release. This information and/or images have been copied into our computers. Unless our office has specifically requested that you return the records, they are yours to keep; please do not return them. Place the records in a safe location for future reference if necessary.