

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name:		
Last	First	Middle Initial
Date of Birth:	Social Security Number:	
I request a copy of medical records from	(date) to	(date
On the above named patient for the following reason(s):		
Change in Primary Care Provider		
Moving or Relocating to another area		
Other: (please explain)		
Name of Releasing Physician or Facility		
Phone:	Fax:	
То:		
Physician, Facility, or Person receiving Records		
Phone:	Fax:	
Signature of Patient or Authorized Representative	Date	
Signature of rations of Authorized Representative	Date	

I hereby authorize the release of all medical records except notes forwarded by a mental health professional, such as a Psychiatrist, Psychologist, or a Licensed Professional Counselor. I hereby release BAPTIST PHYSICIAN NETWORK from liability associated with this release.

Please complete all fields on this form. Omitted information may cause a delay in your request. 01/16