Leading Medical Care
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Board Certified Internal Medicine

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MEDICAL RECORDS RELEASE FORM
PATIENT INFORMATION

Patient Name _____ DOB (MM/DD/YYYY) _____

Street Address _____

City, State, Zip Code _____

Phone _____

RELEASE MEDICAL RECORDS FROM:

Doctor/Hospital _____

Street Address _____

City, State, Zip Code _____

Phone _____ Fax _____

RELEASE MEDICAL RECORDS TO:

Doctor/Hospital _____

Street Address _____

City, State, Zip Code _____

Phone _____ Fax _____

This request and authorization applies to:

Release all healthcare information

Healthcare information relating to the following treatment, condition or dates:

_____

_____

_____Other

____Yes ____No I authorize the release of my STD results, HIV testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will notified that I must give specific written permission before disclosure of these test results to anyone.

____Yes____No I authorize the release of any records regarding drug and alcohol or mental health treatment to the person(s) listed above.

Signature: