



Medical Records Request Form

Patient Information

Full Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Address: _____

Records Requested

Complete Medical Record

Specific Records (please specify below):

Date Range (if applicable):

From: _____ To: _____



Purpose of Request

- Continuity of Care
 - Personal Use
 - Legal
 - Insurance
 - Other (please specify): _____
-

Release Information To/From

Release To:

Name/Facility: _____

Address: _____

Phone: _____ Fax: _____

OR

Release From:

Name/Facility: _____

Address: _____

Phone: _____ Fax: _____

Delivery Method



ALLDAY MEDICAL CARE CLINIC
Serving Children, Adolescents, Adults & Seniors



- Pick Up
- Mail
- Fax
- Email (must be encrypted)

Email Address (if selected): _____

Authorization

I hereby authorize the release of the medical records indicated above. I understand that this authorization is voluntary, and I may revoke it at any time in writing. I also understand that once the information is released, it may be subject to redisclosure by the recipient.

Signature of Patient or Legal Representative: _____

Date: _____

Relationship to Patient (if applicable): _____