



Medical Records Release Form

By signing this form, I authorize you to release a confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below:

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

- Complete Records
- Lab Reports
- Operative Reports
- Care Plan
- Treatment Record
- Other (please specify)
- Pathology Reports
- Medication Record
- Hospital Reports
- Progress Notes
- History & Physical
- Radiology Reports

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

<p>To:</p> <p style="text-align: center; margin-left: 40px;">Inspire Health</p> <p>Address: _____</p> <p> _____</p> <p>Phone: _____</p> <p>Fax: _____</p>	<p>From:</p> <p>Physician: _____</p> <p>Practice: _____</p> <p>Address: _____</p> <p> _____</p> <p>Phone: _____</p> <p>Fax: _____</p>
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The purpose/reason for this release of information is as follows: _____

Patient Name

Signature of Patient or Personal Representative

Patient Date of Birth or Social Security Number

Printed Name of Patient or Personal Representative

Date