Release of Medical Records Form

Patient Information

Name: Sarah Johnson Date of birth: 12/12/1985

Address: 456 Oak St.

City: Anytown State: CA Zip Code: 12345

Phone Number: (555) 555-1234 Email: sarahjohnson@email.com

I, Sarah Johnson, hereby authorize the disclosure of my protected health information to the following individual(s) or entity:

Name of Individual or Entity: Dr. John Doe

Relationship to Patient (if applicable): Primary Care Physician

Address: 101 Main St.

City: Anytown State: CA Zip Code: 12345

Phone Number: (555) 555-9012

I understand that this authorization is voluntary and that I may revoke it at any time, except to the extent that the authorized recipient(s) have already acted based on this authorization. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

I further understand that I am not required to sign this authorization as a condition of receiving treatment, payment, enrollment, or eligibility for benefits.

Signature of Patient or Legal Representative: Sarah Johnson Date: 03/25/2023

Signature of Witness (if required): _____ Date: _____