Medical Records Release Form

HIPAA-style records release & signature

OnlineSignatureForms.com: Free fillable template

The patient named below authorizes the provider to release the health records described to the recipient shown. Store the signed form securely and share records only with the named recipient. This is a general-purpose, HIPAA-style layout, not legal or compliance advice — confirm HIPAA and state requirements.

Patient

Patient name

Date of birth

Records & parties

Records requested (notes, labs, imaging, billing)

Release from (provider / facility)

Release to (recipient)

Purpose of release

Expiration date or event

Authorization

I authorize the releasing provider to disclose the records described above to the named recipient for the stated purpose. I understand I may revoke this authorization in writing, except where action has already been taken, and that it expires on the date or event shown.

☐ I have read and agree to the authorization statement above

Right to revoke: notify the releasing provider in writing to revoke this authorization.

Signatures

Patient signature

Date

Parent / guardian signature (if minor)

Date

Guardian printed name and relationship