Patient Request to Review or for Copies of Records

Patient Information:
Name of Patient _____ Date of Birth _____

Name & address of Covered Entity authorized to release information:

Name & address of entity to receive/review information:

Description of information to be released/reviewed at the request of the patient:

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effect until the requested items have been delivered or the information has been reviewed by the patient.

_____ Date _____
Signature of Patient or Personal Representative

_____
Print or Type Name of Patient or Personal Representative

_____ _____
Description of Personal Representative's Authority (attach necessary documentation)