Island Family Medicine, PLLC
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Medical Records Request

1. I AUTHORIZE:

____
Name of sending person/organization
____
Street Address
____
City State Zip Code
____
Fax Number

2. TO RELEASE TO:

____
Name of receiving person/organization
____
Street Address
____
City State Zip Code
____
Fax Number

3. **INFORMATION TO BE RELEASED:** (Check all applicable)
☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-ray Reports
☐ Electrocardiogram (ECG) ☐ Allergy Record ☐ Immunization

4. **RECORDS FROM THE TIME PERIOD:** ____/____/____ through ____/____/____

5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)
☐ Continued Medical Care ☐ Personal

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requestor may be provided with a copy of this authorization.

Patient's Name (Please Print) ___________________________________

Patient's Signature: _________________________ Date: ___________________

Date of Birth: _______________

Home Phone: __________________