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Medical Records Release Form

Patient Name: _____
Address: _____
Date of Birth: _____ Phone: _____

The information you may release subject to this signed release form is as follows:
___ All Records
___ History & Physical
___ Lab Reports/EKG/Pathology Reports
___ Radiology Reports/X-Rays
___ Other (describe specifically) _____

Reason for request: _____

By signing this form, I authorize Foxhall Internists, P.C. to release the specified confidential health information about me to the physician/person/facility below.

Name: _____
Address: _____
Phone: _____ **Fax:** _____

_____ _____
Patient's signature (or patient's personal representative) **Date**

_____ _____
Printed name of patient's representative **Representative's Title (i.e. parent, guardian, health care provider)**