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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)