



# Authorization for Release of Medical Records

**REQUESTOR REQUIRED DOCUMENTATION:**

- **Spouse/Next of Kin** – Healthcare Power of Attorney, Court-issued Letter of Administration, or This Form Notarized
- **Parent of Minor Child** – Photo ID or This Form Notarized
- **Guardian** – Court-issued Guardianship Papers or This Form Notarized
- **Executor/Administrator/Attorney in Fact** – Court-issued Letters of Administration, or This Form Notarized
- **Patient’s Healthcare Power of Attorney** – Copy of Healthcare Power of Attorney or This Form Notarized

STATE OF: \_\_\_\_\_

COUNTY OF: \_\_\_\_\_

I, \_\_\_\_\_, Notary Public for said county and state, do hereby certify that, \_\_\_\_\_ personally appeared before me and acknowledged that he/she is the

***(You MUST indicate which applies) –***

- |  |                                 |             |
|--|---------------------------------|-------------|
| 1. Spouse/Next of Kin                      | 2. Parent of Minor Child        | 3. Guardian |
| 4. Executor/Administrator/Attorney in Fact | 5. Healthcare Power of Attorney |             |

for \_\_\_\_\_, (patient).

Witness my hand and seal this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

(SEAL)

\_\_\_\_\_  
Notary Public  
My Commission Expires: \_\_\_\_\_