

Authorization for Release of Medical Records

Authorized Representative (Non-Patient Requestor):

☐ Spouse ☐ Parent of Minor Child ☐ Legal Guardian ☐ Executor/Administrator/Attorney-in-Fact
☐ Healthcare Power of Attorney ☐ Other: _____

Documentation of authority may be required.

Name of Requestor: _____

Signature of Requestor: _____ Date: _____

Law Office Attestation (Required for Attorney Requests):

Release of records will not be processed until appropriate legal documentation such as a Court Order, written authorization, Healthcare Power of Attorney, or other required legal authority has been provided **or** until this attestation is completed by the receiving law office.

By signing below, the law office affirms that it has verified the identity of the patient requesting their own records **or** confirmed the legal authority of the requester, including parent of a minor child, legal guardian, executor or administrator of the patient's estate, Healthcare Power of Attorney, or Attorney-in-Fact.

Printed Name: _____

Signature: _____ Date: _____