# MEDICAL RECORDS RELEASE

Date ______________________

Patient Name ______________________ Date of Birth ______________________

I hereby authorize and request you to release complete medical records
in your possession concerning my illness and/or treatment.

Recipient ❑ Hospital ❑ Physician ❑ Self ❑ Other ______________________
Method ❑ Email ❑ Fax ❑ Mail ❑ Patient Portal ❑ Pick-up at office

Recipient contact information (complete all applicable information)

Name ______________________

Address ______________________

Phone ______________________ Fax ______________________ Email ______________________

❑ Release all records

❑ Release only the records from the period between ______________________ and ______________________

Under Federal law, a patient may request a copy of his or her medical records.
A fee may be charged for this service in accordance with State law.

Patient Signature*______________________ Date ______________________

**If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

Requestor information (if not the patient)

Name______________________ Relationship to patient ______________________

Requestor’s Signature ______________________ Date ______________________

Fax or mail this completed form and a copy of the requestor’s photo ID to any practice location. Office addresses and fax numbers may be found on the practice’s website page on uniteddigestive.com. You may also email these required documents to medicalrecords@uniteddigestive.com. If picking up records in person, a photo ID will be required at the time of pick-up.