revolution health
medical center
Simple Changes. Powerful Results.

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Medical Records Release to Another Provider

Name: _____ Date: _____

Date of Birth: _____ SS:_____

Address: _____

_____

❑ I hereby authorize Revolution Health to release of **ALL** my medical records:

OR

❑ I hereby authorize Revolution Health to release **ONLY** the following checked records:

☐ Laboratory Results ☐ History & Physical

☐ Progress Notes ☐ X-ray/Other Diagnostics

Purpose of request: ☐ Treatment ☐ Continued Care ☐ Other_____

Send Records To:

Physician/Clinic Name:_____

Type of Provider: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone:_____ _____ Fax:_____

Patient Signature: _____ Date: _____

This authorization will expire on: _____OR in 12 months if no expiration indicated.

Witness: _____Date: _____