Medical Records Release/Request Form

(*Check One*)
Release _____Releasing information from us to you or your provider
Request _____Requesting information from another provider to us

Date: ________________
Name: _______________________
Date of Birth: _________________
Address: ____
Phone: _________________
Social Security #: _____________________
I authorize the Enclave Family Healthcare, PLC to **release/request** (*circle one*) the following:
Information Requested:

Purpose of Request: _________________________________
Duration of Authorization: ________________________

To/From (*circle one*) Name: __________________________________
Address: ____
Phone and Fax: ____
(It is important that you give as much contact information as you can, especially the provider's name and phone.)

• I understand that this authorization shall be valid through ________________(date), but that I may revoke it **in writing** at any time; any such revocation shall have no effect on disclosures made previously.
• I understand that I have the right to inspect and copy the information to be released.
• I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.
• I understand that the release of information may **not** be re-released to any other person or organization without my written consent.

Signature _____________________________ Date ____________________

Witnessed by ______________________________ Date ____________________