ADAPT Health Coach

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Client/Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed form is as follows:

☐ Complete Records	☐ History & Physical	☐ Progress Notes
☐ Care Plan	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Reports	☐ Treatment Record	☐ Operative Reports
☐ Hospital Reports	☐ Medication Record	☐ Other (Please specify below)

Release my health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

The purpose/reason for this release of information is as follows: _____

Signature: _____

_____ _____

Client/Patient Name Signature of Client/Patient or Personal Rep.

_____ _____

Client/Patient Date of Birth or SSN Printed Name of Client/Patient or Personal Rep.

_____ _____

Date Description of Personal Representative's. Authority

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