Victory Medical

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

In accordance with state law and regulatory agency requirements, health records are the property of Victory Medical and Family Care. A payment of $25.00 is required PRIOR TO request processing.

Please release medical records for the following individual:

Last Name	*First Name*	*Social Security Number*	*Date of Birth*

Release Records
- ❒ **FROM** Victory Medical
- ❒ **TO**

Release Records
- ❒ **FROM**
- ❒ **TO**

Name

Address

City *ST* *ZIP*

Phone *Fax*

Medical Records Requested:

- ❒ **ALL MEDICAL RECORDS**
- ❒ ALL RECENT* MEDICAL RECORDS
- ❒ ONGOING
  (may receive all past and future records)

** Recent = previous 12 months only*

- ❒ Recent* history and physical only
- ❒ Recent* labs only
- ❒ Recent* radiology
- ❒ Recent* non-radiology studies only
- ❒ May release (initials required):
  - ____ *HIV Test results*
  - ____ *Alcohol & Drug Results*
  - ____ *Mental Health Notes*

Purpose of Disclosure:

❒ Application for Insurance ❒ Change of Provider ❒ Attorney Request ❒ _____

This authorization expires 180 days from date signed or on _____.

Patient/Guardian signature *Date*

Office Use Only *Completed by* *Date*

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