
# Medical Records Release Form

By signing this form, I authorize Atlantic Rehabilitation center, Corp 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 facility listed below.

Patient_____ Date of Birth: _____

Address:_____

City/State/Zipcode_____Phone #:_____

**The information you may release subject to this signed release form is the following:**

- ☐ Complete Records
- ☐ Lab Reports
- ☐ Progress Notes
- ☐ Radiology Report Operative Reports
- ☐ Other _____

**Release my protected health information to**:

Name of Person or Facility:_____

Adress:_____

City/State/Zipcode_____ Phone#:_____

**Reason for Release**:

_____

_____ _____

Patient/ Guardian Signature Date

_____

Name