MEDICAL RECORDS RELEASE

Date _____

Patient Name _____ Date of Birth _____

I hereby authorize and request you to release complete medical records
in your possession concerning my illness and/or treatment.

Recipient ❑ Hospital ❑ Physician ❑ Self ❑ Other _____
Method ❑ Email ❑ Fax ❑ Mail ❑ Patient Portal ❑ Pick-up at office

Recipient contact information (complete all applicable information)

Name _____

Address _____

Phone _____ Fax _____ Email _____

❑ Release all records

❑ Release only the records from the period between _____ and _____

Under Federal law, a patient may request a copy of his or her medical records.
A fee may be charged for this service in accordance with State law.

Patient Signature* _____ Date _____

**If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

Requestor information (if not the patient)

Name _____ Relationship to patient _____

Requestor's Signature _____ Date _____

Fax or mail this completed form and a copy of the requestor's photo ID to AIGI Care. Office address and fax number may be found on the practice's website page on aigicare.com. You may also email these required documents to info@aigicare.com. If picking up records in person, a photo ID will be required at the time of pick-up.