# Medical Records Release Form

1. Patient Information

Name:_____ Date of Birth:_____

Address:_____ SS#:_____

City, State:_____ Zip:_____

2. Authorize Records Released From:

Facility Name/Doctor:_____

Address:_____

Phone#:_____ Fax#:_____

3. Authorize Records Released To:

**Nova Medical Center, LLC**
**3501 W Greenfield Ave, Milwaukee, WI 53215**
**P: (414) 643-8815 | F: (414) 643-8816**

4. Information to be Released:

___Medical history, exam, reports
___Operation Reports
___Treatments/Tests
___X-ray Reports
___Mental Health Records
___Prenatal Records
___Lab Reports
___Prescriptions Prescribed
___Consultations
___HIV Test Results
___Alcohol/Drug Abuse Reports
___Any other Reports

5. Purpose for Release:_____

This authorization will remain in effect until _____. This authorization will be effective for medical records generated to the date of signature.

I understand I may revoke this authorization at any time by providing my written revocation.

Patient Signature_____ Date:_____

If signed by person other than patient, state relationship to patient and/or reason why patient was not able to do so:
Patient unable to sign for the following reason: ___Minor ___Incompetent ___Deceased
Legal authority who signed on behalf of patient: ___Parent/Legal Guardian ___Next of Kin