xCures

Request for Release of Patient's Medical Information

Use this form if you are the personal representative of a patient and you need access to the patient's medical information. Patients requesting their own health information should use the form located at https://xcures.com/faq/medical-records-requests/

This form can only be used for one patient. Please submit a separate form for each patient.

Representative who is requesting information

Please print your name below and check the box that best describes your relationship to the patient.

Your full name: _____

Relationship to patient (check one)

- ☐ Legal guardian: Attach guardianship documentation, which must have a court's stamp and signature.
- ☐ Healthcare power of attorney: Attach power of attorney (must specifically include an authorization of the release of medical information).
- ☐ Executor or Administrator: Attach letter of appointment of executorship or administrator, which must have a court's stamp and signature.

Patient whose information will be shared

Name	
Date of Birth	
Address	
City	
State	
Zip	
Daytime Phone	

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Personal information to be shared (check one)

- ☐ Any and all information (including personal, health, demographic and medical records)
- ☐ Only limited information (such as for specific treatments, dates of service or billing details)

  Please describe: _____

Expiration and cancellation

This permission will expire *(check one box only)*:

- ☐ On this date (month, day and year, MM/DD/YYYY) _____
- ☐ When revoked, or upon the patient's death

I understand that the patient or I can revoke this authorization at any time by submitting an access revocation form, available online here: Revoke-a-Previous-Authorization-for-Release-of-Patient-Medical-Information.pdf. I understand that cancellation will not apply to information that has already been released by this authorization.

Authorization and signature

I allow the release of medical information as described above. This information is being released at my request under my lawful authority.

Once xCures verifies that this is a lawful request, and discloses the requested information in furtherance of this request, I understand that I am solely responsible for any subsequent use or re-disclosure of the information I receive, and waive any liability against xCures for reasonably relying upon the information provided by me under this Release.

Signature of personal representative

Signature	
Date	

Attach

You must attach proof of your identity and your lawful authority as the patient's personal representative (See above for examples of acceptable documentation)

IMPORTANT: Please read the form over carefully and be sure you have included all necessary information. If signing this form digitally, you agree that your digital signature bears the same legal authority as your written signature.

Email all completed consent forms to: requests@xcures.com