**Jonathan S. Hott, M.D., P.L.C.**
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# ***MEDICAL RECORDS RELEASE FORM***
# ***(HIPAA RELEASE FORM)***

*I do hereby consent and authorize Jonathan S. Hott, MD to release copies of my medical records.*

**Patient Name:**_____**Date of Birth:**_____
**Address**:_____
**City, State, and Zip Code:**_____**Phone: _____**

**RECORDS TO BE RELEASED TO:**

**Name of Person, Practice, or Facility:**_____
**Address:** _____
**City, State, and Zip Code:**_____

**Please select all documents that apply to your request:**

- O Progress Notes
- O Radiology Reports
- O Pathology Reports
- O EKG, EEG, EMG
- O Emergency Room
- O Other: _____

**Printed Name of Patient or Legally Authorized Representative:** **Relationship to Patient:**

_____

**Signature of Patient or Legally Authorized Representative:** **Date:**

_____