Authorization for Release of Medical Records

Patient's Name: _____

Patient Date of Birth: _____ / _____ / _____

Patient Address: _____
_____
_____
_____

Patient Telephone Number: (_____) _____-_____

Please Release My Medical Records From:

Name of Provider: _____

Provider's Address: _____
_____
_____
_____

Send Medical Records To:

Name of Provider: _____

Provider's Address: _____
_____
_____
_____

I HEREBY AUTHORIZE YOU TO RELEASE MY RECORD AS PROVIDED ABOVE.

_____ _____

Patient's Signature Date

(Parent or Guardian Signature in case of a minor)

Complete this form. Provide a copy of this completed form/authorization to the provider so they may release your medical record as indicated above.