Medical Release Form

Patient Name _____ Date of Birth ____/____/____

SSN _____ Address _____ City _____

State _____ Zip Code ____ _ Phone( ) _____ Email _____

INFORMATION REQUESTED FROM

Name _____

Address _____ City _____ State ____ Zip Code ____ _

Phone( ) _____ Fax( ) _____ Email _____

SEND INFORMATION TO

Name _____ Send by ☐ Mail ☐ Fax ☐ Secure Email

Address _____ City _____ State ____ Zip Code ____ _

Phone( ) _____ Fax( ) _____ Email _____

I, _____(Name), herby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the physician/ person/ facility/ entity that I have listed above.

_____ _____

Printed Name Date

_____ _____

Signature Date