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), hereby grant permission for you to release confidential health inormation about me, by releasing a copy of my medical record, or a summay or narrative of my protected health information, to the physician / person/ facility/ entity

______________________________ ______________________
Printed Name Date

______________________________ ______________________
Signature Date