

MEDICAL RELEASE FORM

Patient Name _____ Date of Birth ____/____/____
 SSN _____ Address _____ City _____
 State _____ Zip Code _____ Phone () _____ Email _____

INFORMATION REQUESTED FORM

Name _____
 Address _____ City _____ State _____ Zip Code _____
 Phone () _____ Fax () _____ Email _____

SEND FORM 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 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

 Printed Name

 Date

 Signature

 Date