## TRUST MEDICAL SERVICES 599 S HAMILTON RD. WHITEHALL, OH 43213 PHONE; (614) 235-9199

FAX: (614) 235-9121

## 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	d by   Mail   Fax   Secure Email
Address City	State Zip Code
Phone ( ) Fax ( ) Email	
(Mama) barby a	rant normission for you to release confidential
I,(Name), herby 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