

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