MEDICAL RELEASE FORM

Patient's name _____

Date of birth ____/____/____

Social Security Number _____-___-_____

Address

_____

_____

_____

Telephone number _____

Please release my medical records from:

Name of provider _____
Provider's address _____

_____

_____

_____

TO:

[ATTORNEY'S NAME AND ADDRESS HERE]

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____Date:

_____
Patient's Signature