



# 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 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