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 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