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