Medical Records Release Form

Patient Name:

[   ]

Date of Birth:

[   ]

Address:

[   ]

Phone Number:

[   ]

Doctor/Hospital to Release Records From:

[   ]

Recipient (Person/Organization to Receive Records):

[   ]

Purpose of Release:

[   ]

Records to be Released:

[   ]

☐ I authorize the release of my medical records as specified above.

Signature:

[   ]

Date:

[   ]

[Submit]