Authorization for Release of Medical Records

Patient Information:

Patient First Name: _____ Last Name: _____ MI: _____
DOB: _____

Information to Be Released From:

Organization or Dr. Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

***Please include all medical records, reports, notes, testing, photographs, procedures, scans, x-ray films, bills, and all other medical information.**

Information to Be Released To:

Organization or Dr. Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Patient Signature: _____ Date: _____

*All records will be mailed unless otherwise specified. Please allow time for processing.

Comments: _____
_____
_____