Records Release Authorization

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Please fill out the entire form below.
After the completed form is received your request will be given to your doctor. Once it is authorized your requested information will be sent to the person listed on this form.

1. I authorize the release of the following medical information:

2. Release the information to:

Name: _____

Address: _____

City, State, Zip _____

Phone: (_____)_____Fax: (_____)_____

3. The reason for this request:

4. Patient Information

Patients Name: _____

Address: _____

City, State, Zip_____

Date of Birth: _____Phone: _____

Patient Signature:_____

Todays Date:_____ Expiration Date:_____