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MEDICAL RECORDS RELEASE FORM

PLEASE PRINT

TODAY'S DATE:_____

I HEREBY AUTHORIZE/REQUEST YOU TO RELEASE THE COMPLETE MEDICAL RECORDS IN YOUR POSSESION CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM _____ TO _____.

PATIENT NAME: _____

DATE OF BIRTH: _____

RELEASE FROM: _____
(DOCTOR OR HOSPITAL THAT HAS YOUR RECORDS)

ADDRESS:_____

PHONE# _____ FAX#_____

SUBMIT TO: _____
(DOCTOR OR HOSPITAL REQUESTING RECORDS)

ADDRESS:_____

PHONE#_____ FAX#_____

PATIENT SIGNATURE:_____
(REQUIRED)