Medical Release Form

Patient Name:_____

Address:_____

City, State and Zip Code:_____Phone:_____

Date of Birth:_____Social Security Number (last 4 digits only):_____

Records Request From:

Name of Physician/Clinic/Facility:_____

Address:_____

City, State and Zip Code:_____

Phone:_____

Records being release to:

Name of Physician/Clinic/Facility:_____

Address:_____

City, State and Zip Code:_____

Phone:_____

Please select document to be released:

__ All Medical Records

__ Lab Results

__Radiology Reports

__Office Notes

__Other

Patient Signature:_____Date:_____