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Authorization for Release of Medical Records

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

Records to be released:

_____

_____

_____

Information Released **TO**:

Physician Name:_____

Address / Practice Location: _____

Fax: _____ Phone: _____

Information Released **FROM**:

Physician Name:_____

Address / Practice Location: _____

Fax: _____ Phone: _____

_____ _____

Signature of Patient (or Medical PoA) Date

Date Requested/Sent: _____ Via: _____ By: _____