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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: _____ Phone: _____

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: _____