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Medical Release Form

PATIENT INFORMATION:

Name:_____ Birth Date:_____ Age:_____ Sex:____

Address:_____ _____

City/State:_____ ZIP:_____

Home Phone # (___)_____ Cell Phone# (___)_____Work Phone # (___)_____

Email Address:_____

RELEASE FROM: _____ (Name of Doctor)

Address: _____(Name of Facility)

Phone: _(_____)_____ _____Fax: _(_____)_____

Reason for record request/release/transfer:

- Change in Insurance from _____ to _____
- Changing facilities/provider networks
- Changing Physician- Reason: _____
- Moving out of the geographical area
- Wish to examine/have a copy of records/Specialist Visit

I _____ am authorizing release of medical records as specified above. This authorization is in effect for the length of time required to complete the request.

There is a $25 fee for each medical record due at time of request.

_____ _____

Patient's Signature Date

Request sent on: _____(Date)