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Authorization for Release of Medical Records

All information must be filled out properly. Please allow 15 days for records to be completed. Thank you.

Release Records From: (please print)

Physcian/Provider: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Release Records To: (please print)

Physcian/Provider: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Patient Information: (please print)

Patients Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Social Security Number: _____

Please state the reason records are being released:

_____

_____

_____

Parent/Legal Guardian Signature: _____ **Date:** _____

Office Use Only:

Date Received: _____ Provider/Administrator Initials: _____
Date Copied: _____ Date Mailed/Pt notified to pickup: _____