Authorization to Release Medical Records

Medical records from this office will not be released to any individual or facility without your written authorization. Please note below all authorized recipients, including other physicians and medical offices:

_____

Name/Facility Name

_____

Address

_____

_____

_____

Name/Facility Name

_____

Address

_____

_____

_____

Name/ Facility Name

_____

Address

_____

_____

_____ Date:_____

Patient Signature (parent/guardian signature if patient is a minor)