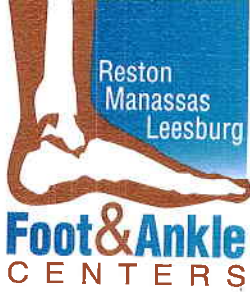

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RECORDS RELEASE AND AUTHORIZATION

Date:____________

Patient Name____

DOB____

I Hereby Authorize And Request You Release My Records To:

Doctor/Facility: ____

Address: ____

____

Phone: ______________________ **Fax:** ______________________

*** The complete medical records in your possession concerning my illness and /or treatment.**

Print______________________________

(PATIENT/GUARDIAN)

Sign______________________________

Form Updated 6-3-2019

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