



AUTHORIZATION OF MEDICAL INFORMATION

Your medical records cannot be released until this form is completed and signed by the patient, parent, or legal guardian.

Please check appropriate box: Releasing medical information from this facility *(fill out section A)*
 Requesting medical information from another facility *(fill out section B)*

Patient Information:

Patient Name: _____

Today's Date: _____ Date of Birth: _____

Mailing Address: _____
City State Zip

RELEASE OF MEDICAL RECORDS-SECTION A

Records to be released to (Name of Provider): _____

Name of Facility: _____

Phone Number: _____ Fax Number: _____

Address: _____
City State Zip

Information to be released: _____
Please provide dates if applicable

Patient Signature: _____ Date: _____

REQUEST FOR MEDICAL RECORDS-SECTION B

Records requested from (Name of Provider): _____

Name of Facility: _____

Phone Number: _____ Fax Number: _____

Address: _____
City State Zip

Information to be released: _____
Please provide dates if applicable

Patient Signature: _____ Date: _____