MEDICAL RELEASE FORM

I authorize:

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To release my records to:

____
(Name of physician and or/facility)

____
Phone Fax

Reason for disclosure: ____

RECORDS TO BE RELEASED:

____ Entire medical chart ____ MRI, CT scans X-rays

____ Lab reports ____ other______________________

PATIENT INFORMATION

PATIENT NAME: ____
(Please print)

PHONE: ______________________________ **DOB:** __________________________

SS#: ______________________________________

ADDRESS: ____

Duration: I understand that this authorization is effective immediately and shall be valid for one year.
Right to Revoke: I understand that I may revoke this authorization in writing at anytime.
Re-use: I understand that no other use will be made of this information without prior authorization from me unless such use is specifically required/permitted by law.

Authorized Signature: ________________________________ **Date:** ________________