AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):
Name: _____ Date of Birth: _____
Claim Number:_____
Insurance ID Number: _____
Address: _____
City: _____ St. _____Zip Code: _____
Phone: _____

Release my Medical Records from:_____

To:
Name: _____
Address: _____
City: _____ ST._____ Zip Code: _____

Please send medical records no later than: _____
Please release a copy of all medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostics tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____ Date: _____