



This is Your Life. Live it Well.

Authorization of Medical Release

Date _____

Patient Name _____

Re: Release of Medical Records

I am a current/ former patient of _____

I authorize and request that you send a copy of my medical records to:

Name _____

Address _____

City, State, Zip _____

Phone number _____

This clinical information will be regarded as confidential and privileged and will be used solely for patient management.

Witness _____
Signature

Patient _____
Signature

Date of Birth _____

SSN# _____