Free Patient Release Form

Patient Information

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Email: _____

Authorization for Release

I, _____, authorize the release of the following information:

Type of Information

[ ] Medical Records

[ ] Immunizations

[ ] X-rays

[ ] Prescriptions

[ ] Other: _____

Send Information To

Name: _____

Organization: _____

Address: _____

Phone: _____

Email: _____

Method of Release

[ ] Fax

[ ] Mail

[ ] Secure Email

[ ] In-Person

Signature: _____

Date: _____