Medical Release Form PDF

Patient Information:

- **Full Name: _____**
- **Date of Birth: _____ SSN: _____**
- **Address: _____**
- **Phone Number: _____**
- **Email: _____**

Information Requested From:

- **Provider/Facility Name: _____**
- **Address: _____**
- **Phone: _____ Fax: _____**

Send Information To:

- **Name: _____**
- **Address: _____**
- **Phone: _____ Fax: _____**
- **Delivery Method: [ ] Mail [ ] Fax [ ] Email [ ] Secure Email**

Authorization: I authorize the release of the following information:

- **Medical Records**
- **Lab Results**
- **X-ray Reports**
- **Billing Information**
- **Other: _____**

Signature: _____

Date: _____