Medical Release Form Template

Patient Details:

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

Medical Information:

- **Physician Name: _____**
- **Clinic Name: _____**
- **Reason for Release: [ ] Treatment [ ] Personal [ ] Insurance [ ] Legal**
- **Type of Information: [ ] Entire Medical History [ ] Specific Record: _____**

Recipient Information:

- **Name: _____**
- **Address: _____**
- **Phone: _____ Email: _____**

Authorization: I hereby authorize the release of my medical information for the purposes stated above.

Patient's Signature: _____

Date: _____