Patient Release Form PDF

Patient's Full Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Authorized Release

Doctor/Hospital Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information to Be Sent

[ ] Complete Medical Records

[ ] Test Results

[ ] Prescriptions

[ ] Other: _____

Delivery Method

[ ] By Fax

[ ] By Mail

[ ] By Email (secure transmission)

I, _____, give permission for the release of the above information to the recipient listed.

Signature: _____

Date: _____