Patient Release Form Template

Patient Name: _____

Date of Birth: _____

SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information to Be Released

[ ] Medical Records

[ ] Lab Results

[ ] Imaging/Diagnostics

[ ] Other: _____

Reason for Release

[ ] Continuation of Care

[ ] Legal Purposes

[ ] Personal Use

[ ] Other: _____

Release To

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax:

_____

I, _____, authorize the release of my medical information to the person or entity listed above.

Signature: _____

Date: _____