Printable Medical Release Form

Patient's Full Name: _____

Date of Birth: _____ Phone Number: _____

Requesting Records From:

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

Release of Information To:

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

Type of Information to be Released:

- **Medical History**
- **Lab Results**
- **Billing Records**
- **Prescription Records**
- **Other: _____**

Purpose of Release:

- **Medical Treatment**
- **Legal**
- **Insurance**
- **Other: _____**

Authorization: I understand the information will be used for the purposes outlined and may include sensitive details. I consent to its release.

Patient Signature: _____

Date: _____