



## Release of Medical Records

Patients Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

### Records to be sent TO:

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Office Address: \_\_\_\_\_

### Records to be sent FROM:

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Office Address: \_\_\_\_\_

I, \_\_\_\_\_ authorize the release of ALL records, clinical notations and x-rays to the listed provider address.

\_\_\_\_\_  
Guardian's name printed

\_\_\_\_\_  
Guardian's Signature