Medical Records Release Form

Client Name: _____

Address: _____

City: _____ State: _____ Province: _____

Country: _____ Zip/Postal Code: _____

Telephone: _____ Fax: _____ Email: _____

Date of Birth: _____ Social Security Number: _____

I authorize the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment during the period of _____ to_____ ; to be sent to the following person or company.

Company: _____

Name: _____

Address: _____

City: _____ State: _____ Province: _____

Country: _____ Zip/Postal Code:_____

Telephone: _____ Fax: _____ Email: _____

Client Signature: _____ Date: _____

This authorization is valid until: _____ .
date