MEDICAL RELEASE

MEDICAL RELEASE FORM

Patient Name: **Date of Birth:**

By signing this form, I authorize to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician / person/ facility / entity listed below:

The information you may release subject to this signed release is as follows:

- ❑ Complete Records
- ❑ History and Physical
- ❑ Evaluation
- ❑ Care Plan
- ❑ Progress Notes
- ❑ Discharge
- ❑ Precautions / Orders
- ❑ Goals
- ❑ Other

Release my protected health information to:

Healthcare professional / facility:

Address:

Telephone Number:

The reason for releasing this information is:

Patient Name **Date**

Patient Signature **Witness**