

PERMISSION TO RELEASE MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Phone Number _____ Social Security No. _____

Records being sent from:

Records being sent to:

The following information is requested and may be released:

All Medical Records

Immunization Records

Periods covering:

From: _____ To: _____

Other: _____

Required:

I do / do not specifically consent to the transmission of my medical records via facsimile (fax) machine.

Permission is hereby granted for release of information.

Signature of patient

Date of signature

Printed name of patient

Witness