MEDICAL RECORDS RELEASE AUTHORIZATION

Patient_____DOB_____

Address_____

_____

Phone_____

Reason for request

_____

If transferring, why?

_____

Which parts of the record are needed?

_____

I, _____, certify the above request
printed name of parent/guardian
is accurate and hereby authorize the release of these records.

FROM:_____

_____

TO:_____

_____

_____
Signature Date

Very large charts or repeated requests may incur a charge.

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