Medical Release Authorization

Patient Name: ____ DOB: _________________________

____I **DO NOT** give permission to release any information about my care on a voicemail or by mailing without a written request from me.

____I **DO** give permission to release my records the following ways:

____Mailed to my address:

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____Leave detailed information on my voicemail at this number: _____________________

____ Via email at this email address: __________________________________

____Faxed to this number: _______________________________

There may be charges associated with receiving my records and if I am requesting my full record, this can take several weeks.

Please refer to the medical release policy for potential charges for your request.

Patient signature: ____ Date: _______________

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