Authorization of Release of Medical Information

Name of Patient(s): Date of Birth

_______________________________________ ______________

_______________________________________ ______________

_______________________________________ ______________

_______________________________________ ______________

I, _____________________________, hereby authorize the release of the necessary medical records as indicated below:

__ Complete Medical Record __Lab Reports

__Immunization Record __X-Ray Reports

__Other (please specify) ____

Dates of Treatment: ________________ to ________________

Release Information To: _______________________________

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____ __________________

Signature of patient Date

____ __________________

Signature of legal parent or guardian (if patient unable to sign) Relationship to Patient

____ __________________

Reason patient is unable to sign Phone Number