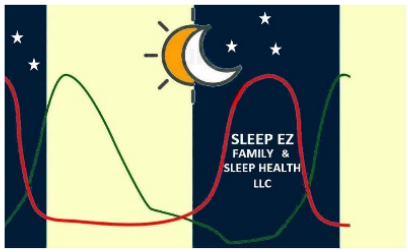

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MEDICAL INFORMATION RELEASE FORM

Patient Name: _____ DOB: _____SSN: _____

Address: _____

Phone: (_____)_____ Email: _____

INFORMATION REQUESTED FROM

Name: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

SEND INFORMATION TO

Name: _____ - send by _____ Mail _____Fax: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

I _____(Name), hereby grant permission to you to release confidential health information about me, by releasing my medical records or a summary or narrative of my protected health information to the physician/ person/ facility/ entity.

_____ _____
Printed Name Date

_____ _____
Signature Date