Medical Release Form

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I, ____, DOB ____/____/_______,

Hereby request that all my medical records be released to:

____ My physician (address information below)

____ Myself (address information below)

Name: ____

Street: ____

City: _____________________________ State: _______ Zip: __________

Phone: ________________________ Fax: __________________________

_____ Please include all confidential testing (infectious disease testing and others)

Records are being released for the purpose of: ___________________________________

____

Patient:

DOB: _____/_____/_____

Name: ____________________________

Signature: _________________________

Witness:

Date: _____/_____/_____

Name: _________________________

Signature: ______________________