

MEDICAL RECORDS RELEASE FORM

Client Name: _____
Address: _____
City: _____ State: _____ Province: _____
Country: _____ Zip/Postal Code: _____
Telephone: _____ Fax: _____ Email: _____
Date of Birth: _____ Social Security Number: _____

I authorize the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment during the period of _____ to _____ ; to be sent to the following person or company.

Company: _____
Address: _____
City: _____ State: _____ Province: _____
Country: _____ Zip/Postal Code: _____
Telephone: _____ Fax: _____ Email: _____

Client Signature: _____ Date: _____

This authorization is valid until: _____ Date