Medical Record Release Form

I, _____, authorize and request that you transfer a copy of all records concerning any diagnosis, prognosis and recommendation, as well as other data pertinent to your treatment of the patient(s) named below.

Client Name: _____

Phone Number: _____

Signature: _____ Date: _____

Patient Name(s): _____ _____

_____ _____

Recipient information

Clinic Name: _____

Phone Number: _____

Fax Number: _____

Please list any additional patients or information below:

Employee signature: _____ Date: _____