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RELEASE OF MEDICAL RECORDS

FROM MY PRESENT PHYSICIAN: _____

_____

_____

Please transfer the medical records of:

Patient Name:_____, DOB:_____

Patient Name:_____, DOB:_____

Patient Name:_____, DOB:_____

Please consider this my authorization to release copies of my child/children's medical records, including mental health & substance abuse to:

_____

_____

_____

X_____ **DATE:** _____
Signature of Patient/Parent (if minor)

OFFICE USE ONLY
Records Released/Mailed; ____/____/____