## **Medical Record Release Permissions Request Form**

## **Patient Information**

Full Name	
t .	
Date of Birth	
Address	
Phone Number	
Email	
Recipient Information	
Recipient Name or Organization	
Recipient Address	_
Recipient Phone Number	_
Recipient Fax Number	
Information to be Released	
Town of Information	
Type of Information	=1
	•
If Other, Specify	

**From Date** 

To Date				
Purpose o	of Release			
Authoriza	tion			
Authoriza □	tion			
	t <b>ion</b> release of my medical reco	rds as described	above.	
☐ I authorize the		rds as described	above.	
☐ I authorize the		rds as described	above.	
authorize the Signature		rds as described	above.	