Medical Records Release & Communication Consent Form

Patient Information

Full Name

Date of Birth

Address

Phone Number

Email

Recipient Information

Recipient (Person/Organization)

Recipient Address

Recipient Phone

Recipient Fax (if applicable)

Information to Be Released

Please describe the specific records/information to be released

Purpose of Release

Purpose

Communication Consent

☐

I authorize communication via phone.

☐

I authorize communication via email.

☐

I authorize release via fax.

Authorization & Signature

Patient / Legal Representative Signature

Relationship to Patient (if not self)

Date