MEDICAL RECORD RELEASE AUTHORIZATION FORM

PATIENT NAME: ____

SOCIAL SECURITY #: ____

DOB: ____

I DO ALLOW THE RELEASE OF MY MEDICAL RECORDS TO THE FOLLOWING: (CHECK ALL THAT APPLY)

___________ SELF (PARENT OR GUARDIAN IF A MINOR)

___________ REFERRING PHYSICIAN- DR. ______________________________

___________PRIMARY CARE PHYSICIAN- DR. __________________________

___________ INSURANCE COMPANY (IF REQUESTED)

___________ REFERRING AGENCY (I.E. BABYNET, CRS, ETC….)

___________ OTHER- ____

SIGNED ____

DATE _______________________________________

WITNESS ____

DATE _______________________________________