Main Family Medical

Release of Information

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Patient Release Form
Authorization to Release Protected Health Information

Patient Name:_____**Date of Birth**:_____

Address:_____**Phone**:_____

I,_____**authorize**, MAIN FAMILY MEDICAL
(insert your name)

to release my protected health information to:

Name:_____

Address:_____

City/State/Zip:_____

Phone:_____

Fax:_____

This request applies to my:

- ☐ Complete medical record
- ☐ Healthcare information limited to the following conditions or dates:

_____

_____

Reason/Purpose for disclosure:

- ☐ Medical
- ☐ Legal
- ☐ Financial
- ☐ Personal

I have read and understood the information in this authorization.

Patient/Guardian Signature:_____**Date**:_____