General Medical Release Form

Patient Information

Full Name

Date of Birth

Address

Phone Number

Email (optional)

Release Authorization

Release Medical Information To:

Purpose of Release (if applicable)

Information to Be Released

Consent

I hereby authorize the release of my medical information as described above. I understand that this release is voluntary and I can revoke it at any time by notifying the provider in writing.

Patient's Signature

Date

Parent/Guardian (if applicable)

Date