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MEDICAL CLINIC

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RELEASE OF RECORDS

By signing this form, I authorize you to release a copy of the medical records, or a summary or narrative of my protected health information, to the doctors/clinic/person/entity listed below.

Patient Information:

Name:

_____

Address:

_____

Personal Health Number & Date of Birth:

_____

Requesting FROM:

Name:

_____

Address:

_____

Phone:

_____

Fax:

_____

*Reason for request:

_____

Releasing TO:

Name:

_____

Address:

_____

Phone:

_____

Fax:

_____

I understand that this is not a service covered by MSP & there may be a fee for this service.

Patient Signature: _____ Date: _____