Medical Records Release

Patient name_____ Date of Birth____/____/_____

SSN____-____-_____ Address_____ City_____

State_____ Zip Code_____ Phone ( )_____

E-Mail_____

INFORMATION REQUESTED ☐ FROM ☐ TO

Name_____

Address_____ City_____ State_____ Zip Code_____

Phone ( )_____ Fax ( )_____

E-Mail_____

Information Requested_____

I, _____(name), authorize the release of my confidential health information, including medical records or summaries, to or from the individual or entity listed above.

_____ _____

Printed Name Date

_____ _____

Signature Date

1626 30th Ave, Suite 201, Fairbanks, AK 99701
Ph: 907-300-6836 Fax: 844-749-2530
Email: reception@GoldenHeartMedicalllc.com