Prime Medical Group
Medical Health and Wellness

MEDICAL RECORDS RELEASE FORM

Client Name: _____

Date of Birth: _____

SSN (Social Security): _____

Address: _____

City: _____ **State:** _____ **Zip/Postal Code:** _____

Telephone: _____ **Fax:** _____

Email: _____

I hereby authorize the release of my medical records or other health care information, which includes intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment during the period of _____ to _____ to be sent to the following person or company.

Company/ person : _____

Address: _____

City: _____ **State:** _____ **Zip/Postal Code:** _____

Telephone: _____ **Fax:** _____

Email: _____

Client Signature: _____

Date: _____

- This authorization is valid until year to date -