

AUTHORITY TO RELEASE PERSONAL HEALTH INFORMATION / MEDICAL RECORDS

I

ADDRESS:

DATE OF BIRTH: / /

REQUEST DOCTOR:

DOCTOR:

ADDRESS:

PHONE: FAX:

ADDITIONAL FAMILY MEMBERS:

NAME: ☐ Male ☐ Female

Date of Birth: / /

NAME: ☐ Male ☐ Female

Date of Birth: / /

NAME: ☐ Male ☐ Female

Date of Birth: / /

NAME: ☐ Male ☐ Female

Date of Birth: / /

TO RELEASE MY/OUR HEALTH INFORMATION/MEDICAL RECORDS TO DOCTOR:

DOCTOR'S NAME: AT CASEY FAMILY PRACTICE.

POSTED/FAXED BY STAFF:

SIGNATURE OF PATIENT:

DATE: / /