Center for Hormonal Health and Well-Being Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:
Patient Date of Birth:

Information to be released: (ie. lab reports, progress note (s), radiology report, complete records, pathology report)

Release my protected health information to the following:
List route you would like information sent (ie. fax, email)
Name:
Address:
Phone number:
Fax number:
Email:

Reason for release:
When will this release expire?

Signature:
Today's Date: