MERIDIAN
Medical Group

MEDICAL RECORD RELEASE AUTHORIZATION

Patient Information: I give permission to release the health information of:

Patient Name: _____

Date of Birth: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____

Email address: _____

Release Information From:

_____

(List applicable Facility(s) and/or Practice(s)

_____

(Phone number) (Fax number)

Release Information To:

_____

(Name of facility, person, company)

_____

(Street Address or PO Box, City, State, Zip Code)

_____

(Phone number) (Fax number)

Signature: _____

Print Name: _____

Relationship to Patient: _____

Date: _____

For Internal Use Only:
Scan document into Consent folder in CB

Revised 11/15