Casey Family Practice
Empowering healthy body & mind
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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:** ..... / ..... / .....