Green Medical and Consulting, LLC
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MEDICAL INFORMATION RELEASE FORM

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

I hereby authorize the release of the following health information:

[ ] Complete Medical Record [ ] Immunization Record [ ] Physicals [ ] Lab/X-ray Reports [ ] Sick Visits
[ ] Other _____ [ ] Period from _____ to _____

The following information will not be released without your signature on the line next to it:

Mental Health (including ADHD/ADD): _____ Alcohol/Drug Information: _____
Sexually Transmitted Diseases/Testing: _____ HIV Testing & Result: _____
Pregnancy: _____ Abortion: _____ Sexual Assault: _____

Reason for request:
[ ] Healthcare/Specialist [ ] Legal [ ] Personal [ ] other (please comment below)
[ ] Moving [ ] Change of insurance [ ] Adult Care [ ] Dissatisfied with care (please comment below)

COMMENTS: _____

_____

_____

[ ] **Records to be sent to:** [ ] **Records to be received from:**

Health Care Provider/Facility: _____

Address: _____

Person completing form (Print name): _____ Relationship: _____

Signature: _____ Date: _____

Please refer to our practice policy regarding release of medical information