Communication Matters *A Professional Corporation*
Speech-Language Pathology *"Enhancing Lives Through Communication"*

MEDICAL RECORDS RELEASE FORM

Date:_____

I hereby authorize the release of medical records for _____
(Patient's name in full)

_____
(Patient's DOB)

To_____
(Name)

_____
(Address)

_____

_____

_____ _____
(Telephone #) (Fax #)

Medical Records_____

_____

_____
(Date and description of records released.)

Documentation Fee (Reviewing & Copying) $_____

_____
Signature of Patient or Guardian

_____
Print Name and Date Picked Up

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