advocare

Records Release Authorization

TO: _____
Doctor or Hospital Name

_____
Address

_____ _____
Phone Fax Number

My permission is granted to disclose to Advocare the complete medical record and all information concerning the medical findings and treatment of the patient(s) named below. I release the practice/physician named above from any laws related to disclosure of confidential or privileged information related to this request.

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

_____/_____/_____
Print Name of Parent or Guardian Date of Request

_____
Signature of Parent or Guardian Relationship to Patient

_____(_____)_____ -_____
Patient Address Patient Phone

_____
Witness

Send to: