Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records to the doctor/clinic/person/entity listed below.

Patient Name: ____

Date of Birth: ____________ **Phone Number:** _____________

My medical records and other confidential health information, for the last 2 years, may be released by you to the following:

Name:____

Address:____

Phone:______________________ **Fax:**___________________

Relationship to Patient:________________________________

Reason:____

Patient's signature:___________________________________

Date:____

Dr. Jill Anderson 101 High Ave Oshkosh WI 54901

920-235-8500