

Medical Release

Patient's Name

Gender

E-mail

Birth Date

Phone Number

Address

Healthcare Provider's Name

Allergy and Medical Information

Medications (over-the-counter and prescription)

I, _____, am informed in detail about the medical diagnosis and the therapeutic approaches regarding my illnesses and hereby authorize the ("Healthcare Provider") to provide necessary treatment to me and release of my medical records for the purpose of medical treatment and consultation. I also authorize the Healthcare Provider to disclose my medical data with other healthcare providers, limited to the purpose of consultation on specific treatment.

This authorization is valid and effective from

to

unless revoked by me earlier.

I have read and understand the purpose and implications of this release and voluntarily authorize the disclosure of my medical information.

Patient's/Parent's/Legal Guardian's Name

Signature

Patient/Parent/Legal Guardian

Name:

Date: