Delta Clinics, PLC

Release of Medical Information Form

Patient's Name: ____

Patient's Date of Birth: ____

Patient's Address: ____

____

Patient's Social Security Number: ____-___-_____

The above patient is requesting the following information to be made available to:
Name of Person/Organization to ***receive*** the information: ____________________

Address receiving information: __________________________________

____

Phone and/or Fax number receiving information: ___________________________

Is the receiver of the information a:
Physician Hospital Out-Patient Center Clinic Hospice

Name of Person/Organization ***releasing*** the information: ______________________

Address releasing information: ____________________________________

____

Phone and/or Fax number releasing information: _____________________________

Dates of Service: From: _______ to ________

Please list any records you **do not** wish to be released: _________________________

Signature of Patient: _____________________________ Date: __________________
If not signed my patient:
Signature of Parent/Guardian: ______________________ Relationship: ___________

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