



Authorization to Release Medical Records

Printed Patient Name

Patient Date of Birth

List specific requested information to be disclosed:

Destination of copied records:

Name:

Address:

City, State and ZIP

Email:

Telephone:

FAX:

If not revoked, this authorization will expire one year from the date of my signature below, or any other date specifically agreed to by all parties and documented at the bottom of this Release.

A \$1.00 per page copy fee will be charged. Records will be copied and mailed after payment is received. Check, VISA, MasterCard, and Discover are accepted. Credit card type, account number, card holder name, expiration month and year, and 3-digit security code (on back of card) must be provided prior to copying.

I, the below signed, authorizes Wyndgate Health to disclose my above requested medical records.

Signature of Parent or Guardian

Date

Patient Signature

Date

Witness Signature

Date