Medical Release Form

Patient name: _____ Date of Birth: ____/____/_____

SSN: _____ Address: _____ City:_____

State: _____ Zip Code: _____ Phone: ( ) -_____

Email: _____

Information Requested from:

Name of facility: _____

Address: _____ City: _____ State:_____

Zip code: _____ Phone: ( )-_____ Fax: ( )-_____

Email: _____

Send Information to:

Stanton Gynecology

2154 Duck Slough blvd. Trinity, FL 34655

727-264-7655

Fax: 727-264-7735

I, _____, herby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information to the physician/facility.

Printed Name: _____ Date: ____/____/_____

Signature: _____