



Medical Release

Date

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

Date

Signature



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