Gastro Health & Nutrition

MEDICAL RECORD RELEASE FORM

Patient's Name:_____ Date of Birth:_____

Social Security #:_____

Please release my medical records from the following physician(s):

Name:_____

Address:_____

City:_____State:_____ZIP:_____

Phone #:_____

Fax #:_____

The release of my medical records is for the continuation of care.

_____
(patient's signature)

_____
(Today's Date)