The Next Level Sports Medicine

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MEDICAL RECORDS RELEASE

Date:_____ **Patient Name:**_____ **DOB**: _____

Requesting Records From(name**)**:_____

Phone/Fax Number:_____

Send Records To(name):_____

Phone/Fax Number**:**_____

- By signing I agree to release and/or disclose all of my medical records including any specially protected records including, but not limited to, psychiatric/psychological conditions, alcohol dependancies, drug dependancies, HIV, etc., for the purpose of medical treatment.

- I understand that this authorization will expire after one year. I also understand that I may revoke this authorization at any time.

_____ _____

Patient/Guardian Signature **Date**