TRANQUIL
Healing Center

Records Release Form

I , _____, agree to the release of my medical information. The specific medical information, including dates/ time periods, being requested and authorized for release is indicated by my initials below.

RELEASED FROM:
Doctor or Healthcare Provider: _____
Address: _____ Phone: _____
_____ Fax: _____

RELEASED TO:
Doctor or Healthcare Provider: _____
Address: _____ Phone: _____
_____ Fax: _____

RECORDS REQUESTED:
____ Chart notes (_____)
____Laboratory Reports (_____)
____Imaging with Reports (_____)
____ Birth Records, including all prenatal, birth and postpartum care (_____)
____ Other _____ (_____)

SIGNATURES:

Patient Name: _____ DOB: _____
Social Security #: _____

Patient Signature: _____ Date: _____

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