



**RELEASE OF MEDICAL INFORMATION**

You may contact me in the following manner:

\_\_\_\_\_ Leave a message on my answering machine at home

\_\_\_\_\_ Leave a message on my cell phone

\_\_\_\_\_ Leave a message at my work number

\_\_\_\_\_ Fax information to \_\_\_\_\_  
home/work

I, \_\_\_\_\_, give permission to Regent Medical to release my pertinent  
(Patient Name)

Medical information, including labs/X-rays to:

\_\_\_\_\_ Name \_\_\_\_\_ Relationship

\_\_\_\_\_ Name \_\_\_\_\_ Relationship

\_\_\_\_\_ Name \_\_\_\_\_ Relationship

\_\_\_\_\_  
For Office Use Only

Form not completed for the following reason(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_