



1002 N. 13th St.  
Boise, ID 83702  
p.208.367.1528  
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**Medical Records Release Form**

**Name:** \_\_\_\_\_

**Birthdate:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Social Security#:** \_\_\_\_\_

**By signing this document, I AUTHORIZE THE RELEASE OF MY CONFIDENTIAL MEDICAL INFORMATION, or that of my minor child to the facilities or persons listed below.**

**\*\*Name and address of facility(s) information is being released to:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Information to be sent:**

all dates of treatment

dates of \_\_\_\_\_ to \_\_\_\_\_

specific (please list)

\_\_\_\_\_  
**Patient/Guardians Signature**

\_\_\_\_\_  
**Date**