Valley Surgical Group
Medical Release Form

This form is to be used when you (the patient) want your medical records to be sent to another entity (i.e. insurance, disability benefits, another doctor).

RELEASE OF INFORMATION

Patient Name _____ Date of Birth _____
Address _____ Social Security Number _____
_____
_____

I hereby authorize Valley Surgical Group to release my medical records to the following:

Name _____

Address
_____
_____
_____

Phone (_____)_____
Fax (_____)_____

Indicate preferred method of record transfer:

Fax / Mail / Personal Pick-Up

Patient/Legal Guardian Signature

_____

Date _____