MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize **Care Eleven Health, LLC** to release confidential health information about me, by releasing a copy of medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:_______________________________________ Date of Birth:_________________________

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name:____

Address:____

City, State, Zip Code:____

The purpose/reason for this release of information is as follows:

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____________________________________ ________________________________

Signature of Patient Date