Medical Records Release Form- Records requested from Eastside Total Health & Lactation, PLLC

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records and protected health information to the provider/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

Release my protected health information to the following provider/person/facility/entity listed here:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Printed Name of Patient: _____

Signature of Patient/Guardian: _____

Today's Date: _____ **Relationship to Patient if Guardian: _____**