Tristate Preventive Health Consultants, LLC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: ______________________ Previous Name: ______________________

Date of Birth: ______________________ Social Security #: xxx-xx-______________________

I request and authorize the release of the indicated medical records by:

Name: **Tristate Preventive Health Consultants, LLC**

Address: **P.O. Box 30068**

City: **Cincinnati** State: **OH** Zip Code: **45230**

Phone: **(844) 879-8742** Fax: **(844) 879-8742**

I request and authorize the medical records to be released to:

Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip Code: __________

Phone: ______________________ Fax: ______________________

This request and authorization applies to the following medical records:

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Patient Signature: ______________________ Date Signed: ______________________

Patient Name (printed): ______________________

FOR OFFICE USE ONLY

The requested records were released on the following date to the above mentioned recipient: __________

Via: ☐ Fax ☐ USPS ☐ Hand-carried by recipient

THIS AUTHORIZATION IS FOR THIS REQUEST ONLY.