

The RINJ Foundation
RELEASE OF MEDICAL INFORMATION FORM

DATE: _____

TO: _____

ADDRESS: _____

TEL: _____

REGARD

CURRENT ADDRESS:

DATE OF BIRTH: _____

The above stated patient has requested the release of his/her medical file. Please find below the authorization to release this information. Thank You.

AUTHORIZATION:

Please release the medical file that you have concerning my medical history to The RINJ Foundation Clinics..

Date: _____

Witness: _____