# Gastro Health & Nutrition

## MEDICAL RECORD RELEASE FORM

**Patient's Name:_____ Date of Birth:_____**

**Social Security #:_____**

**Please release my medical records from the following physician(s):**

**Name:_____**

**Address:_____**

**City:_____State:_____ZIP:_____**

**Phone #:_____**

**Fax #:_____**

**The release of my medical records is for the continuation of care.**

**_____**
**(patient's signature)**

**_____**
**(Today's Date)**