The RINJ Foundation
RELEASE OF MEDICAL INFORMATION FORM

DATE: _____

TO: _____

ADDRESS: _____
_____
_____

TEL: _____

REGARDING (PATIENT'S NAME): _____

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..

Patient's name:
_____

Patient's signature:
_____
(Or patient's parents if under 16years of age)

Date: _____

Witness: _____