Sage®
Communication Clinic

Release Form

Release of/for Information

Please inform our office as to whom you would like us to release a copy of your records to

OR

From whom you would like us to receive the records from:

RE:

_____
(Patient's Name)

To:

_____
(Physician/Specialist/Other Provider)

_____
(Address)

_____

_____
(Phone Number - If Available)

To:

_____
(Physician/Specialist/Other Provider)

_____
(Address)

_____

_____
(Phone Number - If Available)

_____ _____
Patient Guardian Signature **Date**