Medical Release Form

Patient Name: ____
Patient DOB: ____
Patient Phone #: ____
Patient Address: ____
____

I, ____ authorize Dr. Shannon Parks, DO to give and receive information concerning my medical and psychiatric care including treatment records and history to and from ____ at the below address.

Address: ____
____
Office Number: ____

Patient Signature: ____
Date: ____
Witness Signature: ____
Date: ____

I, ____ authorize Dr. Shannon Parks, DO to give and receive information concerning my medical and psychiatric care including treatment records and history to and from ____ at the below address.

Address: ____
____
Office Number: ____

Patient Signature: ____
Date: ____
Witness Signature: ____
Date: ____