1288 S. Governors Ave., Ste B, Dover, DE 19904
Phone: 302-674-4545 Fax: 800-507-3166
reception@lighthouseprimarycare.net

Medical Release Form

Patient Name ___________________________ Date of Birth ____/____/____

Address ___________________________________ City ______________ State ___ Zip Code _________

INFORMATION REQUESTED FROM:

Previous Practice Name ____________________________ Previous Provider Name ______________________

Phone # _____________________________ Fax # _____________________________

SEND INFORMATION TO:

Lighthouse Primary Care
1288 South Governors Ave, Ste B
Dover, DE 19904
Phone: 302-674-4545
Fax: 800-507-3166

I, _____________________________ (Patient or Representative), grant permission for you to release my Medical Record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other healthcare providers, or a summary or narrative of my protected health information, to the provider/facility listed above.

____
Printed Name

____
Signature of Patient or Representative

____
Date