

MEDICAL RECORD RELEASE



To: _____
Name of Medical Facility and/or Doctor

Address

I hereby authorize and request that medical records for the following be released:
(Dependents 18 years old and over must complete and sign and separate Medical Record Release form)

	NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Records to be released to:

STAYWELL INSURANCE
P.O. BOX CZ
HAGATNA, GUAM 96932

Reason for release: FOR HEALTH COVERAGE

Specific information needed: COMPLETE MEDICAL RECORDS

I understand that this authorization will automatically expire upon completion of StayWell's medical review.

Signature of Patient/Legal Guardian

Date

Witness

Date