Medical Record Release
FORM

StayWell INSURANCE

To (Name of Medical Facility and/or Doctor):
Address of Medical Facility and/or Doctor:

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**
520 ROUTE 8
MAITE, GU 96910

Reason for release: **FOR HEALTH COVERAGE**

Specific information needed: **COMPLETE MEDICAL RECORDS**

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

SIGNATURE OF PATIENT/LEGAL GUARDIAN _____ DATE _____

WITNESS _____ DATE _____