Sabrina Johnson
ADVOCATE

MEDICAL RELEASE OF RECORDS

PERSONAL INFORMATION

Full Name

Date Of Birth

Address

Phone Number

E-Mail

Referring Medical Professional:

Are You A Veteran? ☐ Yes ☐ No

THE SIGNATURE AT THE BOTTOM OF THIS PAGE IS THE APPROVAL FOR THE REFERRING MEDICAL PROFESSIONAL TO:

PLEASE CHECK ALL THAT APPLY

☐ DISCUSS MY MEDICAL HISTORY/ TREATMENT PLAN

☐ ELECTECTRONICALLY SEND MY MEDICAL RECORDS

BE SENT TO:

SABRINA JOHNSON ADVOCATE LLC
SABRINA JOHNSON, BCPA
SABRINA@SABRINAJOHNSONADVOCATE.COM
312-854-7178

THE AUTHORIZATION OF THIS FORM EXPIRES ONE YEAR AFTER SIGNATURE

SIGNATURE

DATE