Hagatna MED Clinic
250 Route 4
Hagatna, GU 96921
Phone: 671-475-6500

MEDICAL RECORDS RELEASE FORM

Name: _____

Date of birth: _____

Address: _____

_____

Phone: _____

Patient authorized release of medical records to our facility.
Records will be released from:

Name of Provider: _____

Provider Address: _____

_____

Additional Comments

I acknowledge that I am signing this authorization through an electronic signature pad and that the electronic image will become the original document and that copies of this image may be used in place of the original.

_____

Patient's Signature Date

_____

Parent, Guardian or Representative Signature Date