

**REQUEST FOR RELEASE
OF
MEDICAL RECORDS**

To: _____
Physician's Name (print)

Mailing Address

City State Zip

Fax

Phone

I hereby request that my medical records be released to:

Physician's Name (print)

Mailing Address

City State Zip

Fax

Phone

Date

Patient's Name (printed)

Date of Birth

Signature of Patient or Guardian