REQUEST FOR RELEASE OF MEDICAL RECORDS

I HEREBY REQUEST THAT:
RELEASE MY MEDICAL RECORDS TO:

NAME OF FACILITY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PLEASE INCLUDE THE FOLLOWING:

_____ CONSULTATION REPORTS

_____ OFFICE VISIT NOTES

_____ LAB/X-RAY REPORTS

_____ OTHER:

_____

_____

_____

_____ ALL MEDICAL RECORDS

_____ _____
PATIENT PRINTED NAME DATE OF BIRTH

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

_____ _____
PATIENT SIGNATURE DATE

_____ _____
or AUTHORIZED REPRESENTATIVE SIGNATURE REASON for other Signature