

REQUEST FOR RELEASE OF MEDICAL RECORDS

From:

PHYSICIAN'S NAME

ADDRESS

CITY

STATE

ZIP CODE

TELEPHONE

FAX (IF APPLICABLE)

I hereby request that my medical records be released to:

To:

PHYSICIAN'S NAME

ADDRESS

CITY

STATE

ZIP CODE

TELEPHONE

FAX (IF APPLICABLE)

PATIENT'S SIGNATURE (IF MINOR, PARENT'S)

DATE

COMMENTS:
