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:

_____

_____