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# REQUEST FOR RELEASE OF MEDICAL RECORDS

To (Physician's Name): ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Office Phone #:______________________ Office Fax #: ______________________

**I, ______________________, hereby request and authorize that my medical records be released to:**
Patient Name (print)

Physician's Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Office Phone #:______________________ Office Fax #: ______________________

______________________________ ______________________
Patient Signature Date

______________________ ______________________ ______________________
Date of Birth Social Security # Phone #