Records Release Form

Patient Name: ____________________________________

Patient DOB: _____________________________________

Records Release FROM:

Doctor/Practice Name ____

Address: _________________________________ City/State _______________________________

Phone: __________________________________ FAX: ___________________________________

Medical Information to be released:

_____ Medical records from dates: __________________ to ______________________

_____ ALL Medical records and correspondence from other physicians

Medical Records to be SENT TO:

Doctor/Practice Name ____

Address: __________________________________ City/State ______________________________

Phone: ____________________________________ FAX: _________________________________

I request a copy of my Medical Records to be transferred between the above listed offices.

____ ___________________________________

Signature Date

____ ___________________________________

Name Printed Relationship to patient (if under 18 yrs)