REQUEST FOR RELEASE OF MEDICAL RECORDS

Date:_____

Patient Name:_____ **D.O.B:**_____

I hereby request that my medical records be released to:

Name:_____

Address:_____

Types of information to be released:

- ❑ **All:**_____
- ❑ **Office Visits:**_____
- ❑ **Labs:**_____
- ❑ **History and Physicals:**_____
- ❑ **Radiology Reports:**_____

Dates of Service: From:_____**to:**_____

Signature of Patient or Parent of Patient:_____

Print Name:_____

Relationship to Patient:_____