REQUEST FOR RELEASE OF MEDICAL RECORD

Date : _____

To : _____
Physician's Name

_____
Address

_____
City State Zip

I hereby request that my medical records be released to :

_____
Physician's Name

_____
Address

_____
City State Zip

_____
Physician's Name

_____
Address

_____
City State Zip

SS#_____

Patient's Signature : _____ Date: _____