MEDICAL RECORDS RELEASE

Patient Full Name: _____Date of Birth: _____/_____/_____

Patient Address: _____Cell/Home: _____

City: _____State:_____Zip:_____

I, _____, request _____
(Name /Facility)

to forward a copy of the following medical records:

- ❑ Complete Medical Record
- ❑ Biopsy Report(s)
- ❑ Lab Report(s)
- ❑ Consultation Reports
- ❑ Medication Allergies
- ❑ Allergy Test/Treatment
- ❑ Surgical Procedures
- ❑ Other _____

Please check one:

- ❑ For dates of service from _____/_____/_____ to _____/_____/_____
- ❑ For all dates of service

Release of Information to:

❑ Mail Copies to (address below) ❑ Hold for Patient Pick-up (must show ID) ❑ Fax

Name/Facility: _____Attention:_____

Address:_____

City:_____State:_____Zip:_____

Telephone:_____Fax:_____

I understand that there may be a reasonable medical records copying fee as permissible by law.

_____ _____ ___/___/___
Patient Signature Printed Name Date

_____ ___/___/___
Parent/Legally Recognized Representative Signature / Relationship to Patient Date