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2541 Sand Pike Boulevard
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Request for Release of Medical Records

Patient's Name: _____

Patient's DOB: _____Patient's SSN: _____

Please check one:

_____I authorize the release of my Medical Records from the above named practice **to**:

_____ I authorize the release of my Medical Records to the above named practice **from**:

Name of Company/Physician/Individual: _____

Address: _____

City: _____

State: _____

Zip: _____Phone Number: _____Fax Number: _____

Email: _____

I have the right to revoke this request in writing at any time, except to the extent that action has already been taken to comply with it. Unless revoked, this authorization will remain valid until the disclosure indicated above has been satisfied.

The information being requested is privileged and confidential. It is intended for the individual or entity designated. I am hereby notified that dissemination, distribution, copying, or other use of this information by anyone other than the recipient designated is unauthorized and strictly prohibited.

Signature _____Date _____