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RECORD RELEASE

Date:_____

_____ ____/___/____ _____-_____-_____
Patient Name Printed **DOB** **SS#**

_____
Address

_____ _____ _____
City **State** **Zip**

I am requesting that you forward a copy of my complete medical records to the doctor's office listed below. I hereby release you from all legal responsibility that may arise from this authorization.

SEND COPY OF MEDICAL RECORDS TO:

_____
Doctor's Name

_____
Address

_____ _____ _____
City **State** **Zip**

Thank you.
Sincerely,

_____
Patient's Signature