REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of birth: _____

SSN: _____

I hereby authorize:

_____ (Physician/Clinic Name)

_____ (Address)

_____ (City/State/Zip) (Phone Number)

_____ fax

Release records to : *anti-aging by the sea... A Clinic for Wellness*
1125 N Howe St
Southport, NC 28461
910-477-6290

Purpose: To continue medical care
The consent will expire 1 year after the date signed or sooner at my election.
I place no limitations on any of my medical history.

The authorization can be revoked, but not retroactive to the release of information made in good faith.

Patients Signature _____

Date: _____

Witness: _____