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# RELEASE OF MEDICAL RECORDS

(PLEASE PRINT)

Patient's Name ________________________________________

Date of Birth __________________________

Phone # ______________________________________________

Address ______________________________________________

City, State and Zip Code _________________________________

**I HEREBY AUTHORIZE**

Doctor _______________________ Phone _______________ Fax _______________

Address _____________________________________________

City, State and Zip Code _______________________________________________

**TO RELEASE MY RECORDS TO**

Doctor/Other __________________ Phone _______________ Fax _______________

Address _____________________________________________

City, State and Zip Code _______________________________________________

O Records from other facilities or Doctors    O All Records

O Other __________________________    O Allergy

Signature ___________________________________________ Date _____________

Relationship_________________________