REQUEST FOR RELEASE OF MEDICAL RECORDS

_____

(Name of physician/medical facility to whom records is to be sent)

_____

(Street address of physician/medical facility)

_____

(City) **(State)** **(Zip Code)**

I hereby request that my medical records be released to:

MEDICAL – SURGICAL WELLNESS CENTER

300 W. 80th PLACE SUITE A
MERRILLVILLE, INDIANA 46410
PHONE: (219) 791-9775
FAX: (219) 791-9787

Name of Patient:_____
(please print to expedite record release)

Patient's birthdate:_____

Patient's SS#:_____

Signature of Patient /Legal Guardian:_____

Date signed:_____

Name of Witness:_____

Signature of Witness:_____