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MEDICAL RELEASE INFORMATION

I, _____, herein request of _____
(Print Patient's Name / Date of Birth)

_____
(Doctor or Facility Holding Name)

Address: _____

To forward a copy or summary of the following medical records:

(X) Complete Medical Records (including HIV info)
(X) Complete Medical Records (excluding HIV info)
( ) Biopsy Report(s) ( ) Lab Report(s)
(X) Computed Tomography (CT or CAT) Scans
(X) X-Ray / MRI reports
(X) Medication Allergies
(X) Allergy Test/Treatment
(X) Surgical Procedures
(X) Consultation Reports

for dates of service: from _____ to _____ or All _____

PLEASE SEND MEDICAL RECORDS FROM DOL

FAX BACK TO: 239-210-0225

Patient/Responsible Party Signature: _____ Date: _____

Name Printed (if not patient): _____

(Last Update: 1/17/22)