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**REQUEST FOR RELEASE OF MEDICAL RECORDS**

Date Requested: \_\_\_\_\_ Date Sent: \_\_\_\_\_

TO: \_\_\_\_\_  
(Physicians Name)

\_\_\_\_\_  
(Address) (City) (State) (Zip Code)

**I hereby request that my medical records be released to:**

\_\_\_\_\_  
(Physicians Name)

\_\_\_\_\_  
(Address) (City) (State) (Zip Code)

\_\_\_\_\_  
(Patient's Name)

\_\_\_\_\_  
(Patient's Signature)

\_\_\_\_\_  
(Address) (City) (State) (Zip Code)

\_\_\_\_\_  
(Birth date) (Social Security Number)

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