Authorization For Release of Medical Records

Patient Information (Please Print):

Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests as follows:

From:	**To:**
Name: _____	Name: _____
Address: _____	Address: _____
City: _____	City: _____
State: _____	State: _____
Zip Code: _____	Zip Code: _____
Telephone: _____	Telephone: _____
Fax: _____	Fax: _____

Please send medical records no later than: _____

By my signature I authorize release of medical records:

Patient: _____ Date: _____