



Records Release Form

Date of Request: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security Number: _____

Medical records needed for date of service _____ to _____.

I hereby authorize and request that you release all of my medical records to:

If needed by specific date, please identify: _____

Patient Signature

Date