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RECORDS REQUEST

DATE:_____

TO: _____

_____

I, _____ AUTHORIZE THE ABOVE MENTIONED TO RELEASE MEDICAL RECORDSTO THE FOLLOWNG:

_____

_____

_____

THE MEDICAL RECORDS RELEASED SHOULD INCLUDE THE FOLLOWING:

_____OFFICE NOTES
_____LABORATORY PROCEDURES
_____XRAY REPORTS
_____XRAY FILMS
_____ OPERATIVE REPORTS
_____INSURANCE INFORMATION
_____PRESCRIPTIONS
_____OTHER: _____

_____

PATIENT NAME; _____

DOB: _____SS #: _____

PATIENT ADDRESS: _____

_____

PATIENT SIGNATURE: _____

WITNESS: _____
(OFFICE STAFF SIGNATURE REQUIRED)

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