

MEDICAL RECORDS REQUEST

DATE:

To: _____

I, _____ hereby request that my complete medical records be released to:

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I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at any time. This consent will automatically expire without my expressed revocation 90 days from the date on this form.

PATIENT NAME: _____

PATIENT ADDRESS: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____