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Request for Release of Medical Records

DATE:_____
TO:

_____
Physician's Name

_____
Address

_____
City State Zip Code

I hereby request that my medical records to released to:

_____
Physician's Name

_____
Address

_____
City State Zip Code

- ☐ Progress Notes
- ☐ X-Ray
- ☐ Medical Records
- ☐ Referral
- ☐ Labs/Studies
- ☐ Demographic

Other:_____

_____
Physician's Name

_____
Address

_____
City State Zip Code