

# Request For Medical Record Release

Name and Address of Doctor Whom You Are Requesting Medical Records From:

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Street	Office No.	
City	State	Zip

I hereby request and authorize you to **Immediately Mail or Fax Copies** of all of my pertinent my medical records, films, X-rays and Reports to:

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**Fax Number** (\_\_\_\_) \_\_\_\_\_

My name is (Please Print Clearly): \_\_\_\_\_  
\_\_\_\_\_

My Date of Birth is: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

My Social Security Number is: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I was seen in your office under the following name: \_\_\_\_\_

During the period: From: \_\_\_\_\_ To: \_\_\_\_\_

I appreciate your assistance and urgent help in this matter as it is important to my on going medical care and treatment.

Once again thank you for your prompt attention to this matter.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Representative

\_\_\_\_\_  
Date

Bring, Mail or Fax this form to your medical doctor for his or her action.