CHOICES IN HEALTH

Where leading-edge medicine meets innovative care

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REQUEST FOR RECORDS RELEASE

Physician's Name: _____

Street Address: _____

City: _____State: _____ ZIP Code: _____

Dear Doctor: _____:

The following individual has asked us to request that his or her medical records be released and forwarded to our office:

Patient Name: _____

Birthdate: _____ Social Security Number: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file. Please be sure to include x-ray films and reports.

Thank you for expediting this request. Please send these records to our office address show above.

I hereby authorize the release of all necessary medical records to _____. I wish for them to be forwarded as soon as possible.

Patient's Signature: _____Date: _____
(or parent if patient is a minor)

Patient's Address: _____ City: _____

State: ____ ZIP Code: _____

Signature of Witness: _____