Medical Record Release

Patient Name: _____ Birth: ___/___/___

I am requesting release of my medical records from:

Physician Name: _____

Phone: ( ) -

Fax: ( ) -

Signature: _____ Date: ___/___/___

★ PLEASE SEND ONLY LAST YEAR OF MEDICAL RECORDS ★

Please include most recent Annual (regardless of date), Health Maintenance, Vaccination records, Social/Medical/Surgical History