

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

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