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**Medical Records Release Request**

**Regarding**

Patient Last Name: \_\_\_\_\_ Patient First Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**Records Requested FROM**

Physician or Institution's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**I Hereby Request My Medical Records Be Released and Submitted TO**

Physician or Institution's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Specific Request:** \_\_\_\_\_

\_\_\_\_\_

**Reason for Request:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_  
 Date Signed

\_\_\_\_\_  
 Witness Signature

\_\_\_\_\_  
 Date Signed