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MEDICAL RECORDS RELEASE

Patient Name:____

Date of Birth:_______________________ **SSN:**____________________

To Whom it May Concern,

I hereby request and authorize you to provide a copy of my medical records:

☐ **ALL**

☐ **RECORDS FROM** ___________________ (DATE) **TO** ________________ (DATE).

☐ **LABS AND TESTS**

☐ **SPECIFICS:**____

RELEASED TO:

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RELEASED FROM:

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SIGNED:___________________________________ **DATE:**_____________

WITNESS:__________________________________ **DATE:**_____________

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