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### Medical Records Release

From: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patients Name: \_\_\_\_\_

Patients DOB: \_\_\_\_\_

I request a copy or summary of the following medical records:

- |  |   |
|--|---|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Biopsy Report (s)      |
| <input type="checkbox"/> Lab Report (s)          | <input type="checkbox"/> Consultation Reports   |
| <input type="checkbox"/> Medication Allergies    | <input type="checkbox"/> Allergy Test/Treatment |
| <input type="checkbox"/> Surgical Procedures     | <input type="checkbox"/> Other _____            |
|  | _____   |

Please check one:

For dates of service from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

For all dates of service

Additional comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that there may be a reasonable medical records copying fee as permissible by state law.

\_\_\_\_\_

\_\_\_/\_\_\_/\_\_\_

PATIENT, PARENT/GUARDIAN SIGNATURE

DATE