

## MEDICAL RECORDS REQUEST

DATE:

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

I, \_\_\_\_\_ hereby request that my complete medical records be released to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

-

I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at any time. This consent will automatically expire without my expressed revocation 90 days from the date on this form.

PATIENT NAME: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_

PATIENT'S DATE OF BIRTH: \_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_