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# PERMISSION TO RELEASE INFORMATION

Dr. ______________________________________________

Re: ______________________________________________
(Patient's Full Name)

______________________________________________
(Patient's Date of Birth)

By signature below I am requesting a copy of the Medical Records for the above named patient be forwarded to:

______________________________________________
Name:

______________________________________________
Address:

______________________________________________
City, State, Zip:

For the records, I am requesting these records to be forwarded to the above named individual because:

______________________________________________

______________________________________________

______________________________________________

I understand that there will be a $___________________fee for providing these records and that for your protection, as well as my own, identification may be requested.

______________________________________________
(Signature of Person Requesting Records)

______________________________________________
(Printed Name)

______________________________________________
(Date)

______________________________________________
(Relationship to Patient)

______________________________________________
(Witness)