



## *Request for Release of Medical Records*

---

**Date:** \_\_\_\_\_

**Date span of medical records to be released:** \_\_\_\_\_ **through** \_\_\_\_\_

\_\_\_\_\_ **I hereby request that my medical records be released/sent to: (No Charge)**

\_\_\_\_\_  
(Name of Physician or Facility)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone)

\_\_\_\_\_  
(Fax)

\_\_\_\_\_ **I hereby request to pick up a copy of my medial records. (Charge Applies)**

\_\_\_\_\_ **I hereby request that a copy of my medical records be mailed to me at: (Charge Applies)**

\_\_\_\_\_  
(Patient Address)

\_\_\_\_\_  
(Patient Contact Phone Number)

\_\_\_\_\_  
**(Patient's Full Name Printed)**

\_\_\_\_\_  
**(Patient's Date of Birth)**

\_\_\_\_\_  
**(Patient/Guardian Signature)**