

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: _____

To: _____

Physician's Name

Address

City

State

Zip

I hereby request that my medical records be released to:

Physician's Name (print)

Address

City

State

Zip

Patient's Name (print)

Birth Date

Address

City

State

Zip

SS# _____

Patient's Signature: _____ Date: _____

Generic Medical Records Release Form

Yi-Tong Ma



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