# REQUEST FOR RELEASE OF MEDICAL RECORDS

Pate:		
Го:		
Physician's Name		
Address		
City	State	Zip
hereby request that m	y medical records be r	eleased to:
Physician's Name (print)		
Address		
CRy	State	Ζφ
Patient's Name (print)		Birth Date
Address		
City	State	Ζφ
SS#		
	22.6	
Patient's Signature:		Date:

# **Generic Medical Records Release Form**

Martin M. Shenkman

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