

## REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patients has here by requested the transfer of said records to the Doctor listed and we hereby, request that you release the following patient records:

PATIENT'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

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

RELEASE OF RECORDS TO: Dr. \_\_\_\_\_

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

DATE RECORDS PICKED UP: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

We thank you in advance for your help and cooperation in this matter.