KERRY L. KUHN, MD, LLC

Kerry L. Kuhn, M.D. Donna Hamilton, CNM, MSN

(954) 755-1300 • FAX (954) 755-7799

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
Physician or Hospital Name

_____
Address

_____
City State Zip Code

I Hereby authorize that my medical records be released to:

KERRY L. KUHN, MD, LLC
1725 N. University Drive
Suite 440
Coral Springs, FL 33071

Please include the following information:

- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Pathology Reports
- ☐ Labor & Delivery, Prenatal Records
- ☐ Office Records

_____ _____ _____
Patient's Name (print) DOB Telephone #

_____
E-mail Address

_____
Patients' name at time of procedure / Date of Procedure

_____ / _____ _____
Patient's Signature Witness Date

_____ _____
Signature of employee releasing records Date