MEDICAL RECORDS RELEASE REQUEST

I, ____,
PATIENT'S NAME

request that you release a copy of:

(Please specify)

- ❑ Complete Medical Record
- ❑ Pap Smear/Pathology Reports
- ❑ Other _______________________________

For medical data or results pertinent to treatment of me from ______________ to __________________.

Specify the purpose of request:
____
____

____ Date of request

________________________________ Patient's signature

__________________ Date of Birth

For office use only

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