

Carol McKenzie, MD, LLC

Medical Records Request

To: _____

Address: _____

Ph: () _____ Fax: () _____

I, _____, hereby request that my medical records be:

___ Released to ___ Released from:

Carol McKenzie, MD
Robert Pearl, DO
Yara Hatem, ARNP
3100 Coral Hills Dr, Suite 205
Coral Springs, FL 33065
Ph. 954-341-1520
Fax 954-341-1528

Please release:

_____ My entire medical file including my office notes, labs, and x-rays.

_____ Specific results which include:

Please state the reason for release:

Patient Signature

Date of Birth

Witness

Date