Request for Release of Medical Records

TO: _____
Physician's name (print)

_____
Address City State Zip

I hereby request that my medical records be released to:

_____
Name (print)

_____
Address City State Zip

_____
Patient's Name (print) Date of Birth Social Security Number

_____
Patient's/Guardian's Signature **Date of signature** *

Note: _____ **HIV** test results (if any) are to be released.
(patient to sign)

* ***This release is valid for sixty (60) days from the date of the signature.***