REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____

MAIDEN NAME (IF APPLICABLE): _____

ADDRESS: _____

CITY _____ STATE _____ ZIP CODE: _____

PREVIOUS PHYSICIAN'S INFORMATION

PREVIOUS PHYSICIAN NAME: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE: _____

PHONE NUMBER: _____ FAX NUMBER: _____

☐ ALL RECORDS
☐ PARTIAL RECORDS: APPROXIMATE DATES OF TREATMENT: _____

I, hereby, authorize *the physician stated above* to release any and all information contained in my medical record to:

John K. Appelbaum, M.D.
Timothy C. Philpott M.D.
Gigi Maminta-Streiff M.D.
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PATIENT'S SIGNATURE: _____DATE: _____