

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:

Timothy C. Philpott M.D.
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Jennifer A. Meyer M.D.
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PATIENT'S SIGNATURE: _____ DATE: _____