

RECORDS RELEASE FORM

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Please fill out every portion of this form to ensure correct and timely release of information. Patients 18 and older **MUST** fill out and sign this form for themselves. Upon receipt of this completed letter, we will be happy to forward the records. Thank you for your past association with our office!

Please print name and DOB of patient(s):

1. _____
2. _____
3. _____

Please print:

1. Office Name: _____
2. Address: _____

3. Office Email: _____
4. Office Phone Number: _____

Signature: _____

Date: _____

**** Any files or x-rays that need to be transferred will take up to 48 hours ****

***** Please plan to request and submit accordingly. Thank you *****