

## REQUEST FOR RECORDS RELEASE

PATIENT INFORMATION	
LAST NAME	FIRST
DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	
CITY	STATE, ZIP
DAYTIME PHONE NUMBER (    )	
<b>REQUEST FOR RECORDS RELEASE</b>	
<b>FROM:</b>	
PHYSICIAN NAME	
ADDRESS	
CITY	STATE, ZIP
PHONE	FAX
<b>I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY COMPLETE MEDICAL RECORDS INCLUDING ALL LABORATORY TESTS TO:</b>	
<input type="checkbox"/> CRAIG MOSS, M.D.	<input type="checkbox"/> MARC TACK, D.O.
<input type="checkbox"/> DEBRA KARNASIEWICZ, M.D.	<input type="checkbox"/> CHARLES KUTLER, M.D.
<input type="checkbox"/> MICHAEL SHERAN, M.D.	
<b>BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION.</b>	
<b>X</b>	
PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (SIGNATURE)	DATE OF SIGNATURE
PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (PRINTED NAME)	RELATIONSHIP OF OTHER THAN PATIENT
<b>X</b>	
WITNESS (SIGNATURE)	DATE OF SIGNATURE
THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM THE DATE SIGNED ABOVE.	

