MEDICAL RECORDS RELEASE

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I, _____, hereby authorize the release of any and all medical records relating to my care during the period of _____ to _____.

PATIENT'S NAME: _____

DATE OF BIRTH:_____ **PHONE**:(_____) _____-_____

ADDRESS:_____

CITY:_____ **ST**:_____ **ZIPCODE:**_____

SIGNATURE:_____ **TODAYS DATE:**_____

PLEASE CHECK ONE OF THE FOLLOWING:

☐ 1. **PLEASE SEND MY MEDICAL RECORDS TO DR. HARDY FROM**:

Dr/Hospital: _____

Address _____

City _____ **St** _____ **Zip** _____

Phone(_____) _____-_____ **Fax** (_____) _____-_____

☐ 2. **PLEASE SEND MY MEDICAL RECORDS FROM DR. HARDY TO**:

Dr/Hospital: _____

Address _____

City _____ **St** _____ **Zip** _____

Phone (_____) _____-_____ **Fax** (_____) _____-_____

☐ 3. **PLEASE RELEASE MY MEDICAL RECORDS TO MYSELF** (there is a **minimum fee** of **$25** for medical records).