

COMPLETE WOMEN'S HEALTHCARE

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**MEDICAL RECORDS RELEASE FORM**

Patient's Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please release my medical records from the following physician(s):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

The release of my records is for continuation of care. This document is to expire six (6) months from date of signature.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date