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A Medical Corporation

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REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby request that my medical records, including patient history, lab tests, x-ray reports, skin test results, recipe for antigen and antigens to be released by the physician below. Please forward these records to the physician as indicated above.

Physician Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone/Fax: _____

Patient Name: _____

Date of Birth: _____

Patient/Parent's Signature: _____ Date: _____

Requesting Medical Records From: _____ to _____