Medical Records Release Request Form

I HEREBY AUTHORIZE AND REQUEST,

(NAME OF PHYSICIAN/FACILITY) _____

TO RELEASE MY MEDICAL RECORDS TO THE FOLLOWING PHYSICIAN:

Cher Aymond, MD

4605 N University Ave

Carencro, LA 70520

PHONE: 337-565-2239

Email: doc@chermd.com

Fax: 337-570-1251 If more than 10 pages, fax to 603-600-8938

SPECIAL INSTRUCTIONS PER DR. AYMOND: PLEASE INCLUDE ONE PROGRESS NOTE FROM PAST 6 MONTHS TO 1 YEAR SHOWING PATIENT'S CURRENT DIAGNOSIS THAT QUALIFIES FOR MEDICAL MARIJUANA RECOMMENDATION. FOR CHRONIC PAIN PATIENTS, PLEASE PROVIDE MRI. FOR PTSD PATIENTS, PLEASE PROVIDE ONE PSYCHIATRIST PROGRESS NOTE.

PATIENT NAME: _____

DATE OF BIRTH: _____

HOME PHONE: _____ CELL: _____

ADDRESS: _____

_____

_____

AUTHORIZED SIGNATURE: _____

DATE: _____ RELATIONSHIP TO PATIENT: _____