Request for Medical Records

Release of medical records for:

(Please enter your full name)

DOB:

EMIS Number: *(if known)*

Please release my medical records related to treatment for: *(please indicate the medical condition)*

from to *(date)*.

This information will be used to further assist in my medical care, and should be sent to:

Address:

Please bill me for costs associated with providing copies of my records, and I will remit payment promptly upon receipt of the records.

Signed: Date:

Authorized by CMO

Print Name: Signature: Date: