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RELEASE OF RECORDS

I, _____, authorize _____to release a copy of: _____ pertaining to my case to:

Name: _____
Address: _____
_____
Phone #: _____
Fax #: _____

Please send the requested records by fax to the facility listed above, unless stated otherwise. If the records are more than 25 pages please mail to the address above.

_____ Mail to patient Date mailed:_____
_____ Patient to pick up Date Picked up:_____
_____ Fax to above name Date faxed: _____

_____ Original ultrasound pictures have been released to the patient. Patient is responsible for returning the pictures to our office.

Patient Name: _____DOB: _____

Patient Signature:_____Date:_____

Do you plan to follow up with our office? Yes No

Please allow 5-7 Business days for us to complete your request.