Montgomery SPORTS MEDICINE CENTER

Eran Kessous, M.D.

PATIENT REQUESTED RECORDS RELEASE

DATE:_____

TO:

_____
_____
_____
_____ Fax Number:_____

FROM:

Patient Name:_____ Date of Birth:_____
Patient Address:_____
_____ Phone Number:_____
_____

I, _____(Patient Signature) hereby request that you release my medical records and send them to the individual or business noted below:

_____
_____
_____
_____
_____

I would like to have the following information in my medical record to _____.

Everything, the complete record
Everything in the record prior to _____.
Everything in the record from this time forward _____to_____.
Everything in the medical record that relates to the following conditions and/or treatments:

_____
_____
_____
_____
_____

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