

# Records Release Form

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release my records/x-rays

Release to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

