Healthy Heartbeat, PC

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405.231.8882 OR 1.877.RIHA.911

REQUEST FOR RELEASE OF MEDICAL RECORDS

PHYSICIAN'S NAME _____

ADDRESS _____

CITY, STATE, AND ZIP _____

PHONE NUMBER: _____ FAX NUMBER: _____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

PHYSICIAN'S NAME _____

ADDRESS _____

CITY, STATE, AND ZIP _____

PHONE NUMBER: _____ FAX NUMBER: _____

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL DISESAAE, INCLUDING HEPATITIS, SYPHILIS, GONORHEA, HIV, AND AIDS.

_____
Signature of patient

_____
Parent/Guardian (if patient is a minor)

_____
Date