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REQUEST FOR MEDICAL RECORDS

Date_____

To: _____

Address_____

City,State, Zip_____

Telephone Number_____ **Fax**_____

I hereby authorize and request that you release to the medical office of Samuel R. Williams, M.D., P.A. the following:

[ ] newborn records

[ ] hospitalization records for_____

[ ] emergency room records _____

[ ] office medical records

[ ] consultation reports

[ ] diagnostic studies, lab results _____

[ ] other_____

This information is for the following patient(s)

Name	**Date of Birth**
_____	_____
_____	_____
_____	_____

Relationship to Patient(s) [ ] patient [ ] guardian [ ] self [ ] other_____

Signature_____

Print Name _____