

# REQUEST FOR RELEASE OF MEDICAL RECORDS

To: \_\_\_\_\_  
Name of Physician, Hospital or Facility

Address: \_\_\_\_\_  
Address City State Zip Code

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

From: \_\_\_\_\_  
Name of Patient

## Re: Request for Release of Medical Records

I hereby request that my medical records, without limitations, including any laboratory results and x-rays, be released to:

Michael J. Hattan D.P.M.  \_\_\_\_\_  
Arthur A. Walton D.P.M. \_\_\_\_\_  
355 Placentia Ave, Suite 302 (or) \_\_\_\_\_  
Newport Beach, CA 92663 \_\_\_\_\_

This authorization releases my medical records for the following designated purpose:

\_\_\_\_\_

This release is valid for 30 days after this date.

**I understand that I am entitled to receive a copy of this release.**

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Print Name of Legal Guardian (relationship), if applicable

\_\_\_\_\_  
Witness