Request for Records Release

Request for Records Release

Physician's Name: _____

Mailing Address: _____ **City**: _____

State: _____ **Zip Code**: _____ **Phone#:** _____ **Fax#:** _____

Dear _____,

The following patient has asked us to request that her medical records be released and forwarded to our office:

Patient Name: _____

Date of Birth: _____ Last 4 of Social Security #: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in her file. Please be sure to include x-rays and reports.

Thank you for expediting this request. Please send/fax these records to our office address:

Premier Women's Health
14231 Seaway Road, #3004
Gulfport, MS 39503
Fax: 228-206-1917
I hereby authorize the release of all necessary medical records to:
Dr. Donielle Daigle/ Dr. Michael McKay /Dr. Elaine Kao

Patient's Signature: _____**Date**: _____
(or parent if patient is a minor)

Signature of Witness: _____