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/ Cherry Graves, WHNP

Patient's Signature: _________________________________**Date:**_____________________

(or parent if patient is a minor)

Signature of Witness: ____

Premier Women's Health
14231 Seaway Road, #3004
Gulfport, MS 39503
Phone: 228-206-1905 Fax: 228-206-1917
www.mspwh.com