

Forms/Record Release

Today's Date: _____
Patient Name: _____ DOB: _____
Phone Number: _____

_____ Call to pick up
_____ Mail
_____ Fax

Please complete the following release of information request:

I hereby authorize and request WGH, M.D., P.C. to release the following information concerning my illness and/or treatment.

_____ Release Records (please specify if you do not wish to have all dates of service released)
_____ Complete Form

Release records/Send form(s) to:

Name _____

Address _____

Fax _____ Phone _____

Signed _____

Patient or Representative Signature

PLEASE ALLOW 5-7 DAYS FOR PROCESSING