Request for Medical Records

Date:________________________

I, ____ Hereby request a copy of my medical records as stated below:

RELEASE RECORDS FROM:

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☐ **Release all medical records**

☐ **Release Medical Records as stated:**

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Release Records to: Kushner Wellness Center

(562) 528-9792 Fax: (847) 241-8424

Patient Signature: ____

Patient Name:____

Date of Birth:_____________________ **Relationship:**_____________________