Medical Records Release Form

Patient Name: ____

Date of Birth: ____________________ Phone: ____________________

______________________, hereby give consent for Metropolitan OB/GYN, PA
(Patient Name)

to release my medical Records to:

❒ Office (Please complete Office information below)

Office ____

Contact: ____

Address: ____

Phone Number ____

Fax Number: ____

__________ I give consent to my medical records to be sent by fax I
Initial
understand that my privacy will be protected and only those records that have been requested will be released.

Records & Dates Requested: ______________________________________

____ ____________________

Signature of Patient Today’s Date