☐ 7583 Wall Triana Hwy. ☐ 46 Shields Rd. ☐ 12287 231/431 North

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Medical Record Release Form

Date: _____

I hereby authorize ***Urgent MedCare*** to send a copy of my records to:

_____

_____

_____

_____

I understand that I will be responsible for any charges or copying fees, related to the release of the records, which may be charged by the above-named entity disclosing the records.

Patient's name: _____ Date of birth ___/___/___

Patient's address: _____

_____

Patient's Signature: _____

Parent's Signature: _____
(If patient under 18)

Witness: _____