FORM 3

DRS. MOORE & STOCKSTILL, P.C.

Request for Release of Records

PATIENT NAME: _____

Social Security # __ __ __ - __ __ - __ __ __ __ Birth Date: _____

<u>RECORDS TO BE RELEASED FROM</u>:

Name: _____

Doctor's Office / Medical Facility: _____

Address: _____

Fax: _____ Phone: _____

<u>I HEREBY AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION</u>:

_____ Last yearly exam

_____ Last progress note since yearly exam

_____ Last pap

_____ Last mammogram

_____ Last bone density / DEXA

SIGNATURE: _____ Date: _____

Information must be completely filled out in order for request to be processed. There is a 7-10 business day processing time; your records are not guaranteed to be transferred prior to that time. There is no fee for record transfer to another medical facility. There is a fee for personal or professional record requests