Medical Records Release Form

To Dr.______________________________ Date____________________

I hereby authorize you to release my medical records, specifically:

_____ Findings of medical care
_____ Alcohol or drug abuse information
_____ Hospital records
_____ Clinic notes
_____ Treatment
_____ Lab/X-ray reports
_____ Psychiatric/Psychological care/exam
_____ Diagnosis
_____ Surgery notes
_____ Other (____)

as they apply to me during the period from ____________ to ____________, or the specific information related to:

____

These records are to be sent/faxed to:

Kriz Retsema, NCTMB, CLT
PO Box 2538
Garden City, KS 67846
Fax: 888-693-1159 Phone:620-290-0507

___________________________ **Patients Name**

___________________________ **D.O.B.**

____

___________________________ **Social Sec.#**

____

___________________________ **Patients Address**

___________________________ **Patients Phone #**

___________________________ **Signature of Patient or Guardian**

___________________________ **Signature of Witness**