Authorization to Release Medical Record

Patient Name._____
Address._____
Phone._____

Date: _____

To: Dr. _____

Address._____
_____

P._____ F._____

RE: Authorization to release medical records for (patient name)_____,
DOB_____ to Dr. Brian Davison at The Vanishing Vein.

Dear Dr. _____,

I am writing to authorize the release of my records to Dr. Brian Davison at The Vanishing Vein. Please release all medical records in regards to:

_____
_____.

Please send release my medical records to:

Dr. Brian Davison at The Vanishing Vein
61 Lincoln St, Suite 115
Framingham, MA 01702
P.508-626-8346
F.508-626-8343

If you have any questions, please contact me.

Sincerely,

_____
Patient Name Printed.

_____
Patient Name Signed.