REQUEST FOR RELEASE OF MEDICAL RECORDS OR X-RAYS

BAY STREET
ORTHOPAEDICS & SPINE

To

PRINT PHYSICIAN'S NAME

Address

City State Zip

☐ I hereby request the release of my medical records including office notes, testing results regarding:

NOTE APPROXIMATE DATES OF SERVICE

☐ X-ray, MRI, CT Films (actual films or CD)

INDICATE BODY PART

☐ Please release records to me at:

Address

City State Zip

☐ Please release records to provider noted above.

☐ Please release records to person (other than myself) noted below:

Name

Fax Number Phone Number

Address

City State Zip

Patient Name (print)

Phone Number Date of Birth

Patient Signature Date

PARENT SIGNATURE FOR MINOR

Date Released

Patient #

Bay Street Provider