

MEDICAL RECORDS RELEASE

TO: _____
Physician or Hospital

Street Suite

City

State Zip

Phone Fax

I request that a copy of all my medical records be released to:

Dr. _____

**c/o Doyle Park Family Medicine
510 Doyle Park Drive
Santa Rosa, CA 95405**

(707) 526-1800 Fax (707) 526-9352

Patient's Name

Birth Date

Patient's Signature

Today's Date