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Jennifer L Helton, MD

CONSENT FOR MEDICAL RECORDS RELEASE

From: _____
_____
_____
_____

I request a copy of the following medical records:

____ **Complete Medical Records**
____ **Biopsy Report(s)**
____ **Lab Report(s)**
____ **Consultation Reports**
____ **Medication Allergies**
____ **Allergy Test / Treatment**
____ **Surgical Procedures**
____ **Other** _____

LAST NAME _____ **FIRST** _____

STREET _____

DATE OF BIRTH _____ **SSN** _____

I herby release you from all legal responsibility or liability that may arise from this authorization

_____ _____
Patients Signature **Date**

_____ _____
Witness **Date**

There is a processing fee to release medical records.