Records Release Form

Dr.

☐ Attaran	☐ Cerami	☐ Elias	☐ Rechani
☐ Bazzi	☐ Correa	☐ Hurwit	☐ Tzur
☐ Bryan	☐ Coy	☐ Lister	☐ Zide

I, _____ hereby authorize M.I.C.C. to release all my medical records or copies such as labs, EKG, HIV, CXR, echo reports, exams, procedures, etc., and request that they be transferred to:

____ Myself _____ Another Physician

____ Other (please specify): _____

Please mail all records to the address below:

_____

_____

_____

_____ _____

Patient Name (print) Patient Signature

_____ _____

Patient Date of Birth Social Security Number

_____ _____

Date Witness

Do not write below this line. Office use only.

Requested by: _____ Date: _____ Received by: _____

Sent on: _____ By: _____ Via: _____