REQUEST FOR RELEASE OF MEDICAL RECORDS AND/OR REPORTS.

It is the policy of this Practice to ensure the person requesting the release of documents has the legal right to do so.

In order to protect the privacy of our patients/clients it is necessary that you complete, sign and return this form as proof of identity.

Please have your signature witnessed in the area provided hereunder.The witness must print their name as well as sign. This document will be kept on file at this Practice. Alternatively you can apply in writing, stating your full name, address and date of birth and also with a witness to your signature.

The witness must print their name as well as sign. Please include the details of your request in your letter.

Your written request will be kept on file at this Practice.

I .....

Date of birth .....

Address .....

request the release of a copy of my health information/report

Signature……

Date……..

Witness- name ……..

Witness – signature……...

Date……..