**CONSENT TO RELEASE MEDICAL INFORMATION**

DATE:

TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RE: (affix patient label)

I hereby give consent to have my medical records as requested released from:

Facility/Specialist/Previous HCP

To Dr. Kelley Wright

Requested Records:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_