REQUEST FOR MEDICAL RELEASE

Physician's Name: **Cook & Siu, P.C**

Street Address: 3450 Old Washington Rd. Ste 103
Waldorf, MD 20602
Phone (301)472-4290 Fax(240)607-3609

Dear Doctor: ____
(BE SURE TO ADD FIRST AND LAST NAME OR TELEPHONE NUMBER)

The following individual has asked us to request that his/her medical records be released and forwarded to our office:

Patient Name (Print): ____

Date of Birth: ____________________ Social Security Number: ______-_____-______

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in you file.
Please be sure to include X-ray films and reports.

Thank you for expediting this request. Please sent these records to our office address shown above.

I herby authorize the release of all necessary medical records to Cook and Siu, P.C.
I wish for them to be forwarded as soon as possible.

Patient's Signature: ______________________________ Date: ________________
(Or parent if patient is a minor)

Patient's Address__________________________ City____________ State____ Zip________

Signature of Witness_________________________________