

Medical Records Release

Patient's name _____
Date of birth ____/____/____
Social Security Number _____-____-_____
Address _____

Telephone number (____) ____-_____
Please release my medical records from:
Name of provider _____
Provider's address _____

TO: Waverly Internal Medicine LLC. 11165 Stratfield Court 1st Floor
Marriottsville, MD 21104 (410) 442-8065, Fax (410) 442-8067

Please release:

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

Patient Name Date
