1-833-373-5323(PHONE)

1-866-855-0875 (FAX)

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**RELEASE OF MEDICAL RECORDS**

Patient Name: ____________________________________________________

Date of Birth:_____/_____/______ Phone: (_____)_________-______________

Address:_________________________________________________________________,

I Grant Dr.____________________________________________ permission to release my medical record information relating to my medical history to RELEAF SPECIALISTS via fax @ 1-866-855-0875 or email info@releafspecialists.com, or mail to 5155 Keiners Lane, Pittsburgh PA, 15205.

Please Include a copy of most recent office note Or Copy of Past Medical History showing the diagnosis or condition of: __________________________________

_________________________________________________ _______________

Patient Dated