

**Dr. Lara Varisco Leonhardt, MD**

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| **Request For Release of Medical Records** |

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| --- |
| I, |
| *Patient Name (please print)* |
|  |  |  |  |
| *Address* | *City* | *State* | *Zip* |
|  |  |  |
| *Date of Birth* | *Social Security Number* | *Phone Number* |

I hereby authorize release of my medical records **TO / FROM**:

|  |
| --- |
|  |
| *Name* |
|  |  |  |  |
| *Address* | *City* | *State* | *Zip* |
|  |  |  |
| *Phone number* | *Fax Number* |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Reasons records are being requested for:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| □ | Insurance claim | □ | Review by attorney | □ | Care by physician |
| □ | Disability | □ | Continuing care | □ | Other (Please specify: |

 |  |
| *Person (or Legal Guardian) Signature* | *Date* |
| *Witness Signature* | *Date* |