bee well logo copy.tif

**Dr. Lara Varisco Leonhardt, MD**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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* |