



*Women's Healthcare of Kendall, LLC*

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**MEDICAL RECORDS RELEASE REQUEST**

I, \_\_\_\_\_,  
**PATIENT'S NAME**

request that you release a copy of:

(Please specify)

- Complete Medical Record
- Pap Smear/Pathology Reports
- Other \_\_\_\_\_

For medical data or results pertinent to treatment of me from \_\_\_\_\_ to \_\_\_\_\_.

*Specify the purpose of request:* \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date of request

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date of Birth



**FOR OFFICE USE ONLY:**

Prepared by: \_\_\_\_\_

Date/given: \_\_\_\_\_