Visalia Women's
Specialty Medical Group, Inc.

1700 S. Court Street Suite B | Visalia, CA 93277-4931
P: 559-741-1202 | F: 559-741-0123 | www.vwsmg.com

MEDICAL RECORD RELEASE FORM

PATIENT NAME _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ PHONE: _____

I hereby authorize: Visalia Women's Specialty
1700 S. Court Street | Visalia, CA 93277

to provide copies of my medical records to: _____
Name of Doctor/Medical Provider/Clinic

ADDRESS: _____

_____

DATE OF TREATMENT: From: _____ To: _____

Mail Record: _____ Pick up record: _____ F ax: _____

PURPOSE OF DISCLOSURE _____ Medical Care _____ Personal

Records requested by:

NAME _____

SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT: _____