O&O ALPAN LLC.

11212 Waples Mill Road, Suite 100, Fairfax, VA 22030
Phone (571) 308-1900 Fax (571) 308-1919

MEDICAL RECORDS RELEASE FORM

Patient's name: _____

Date of birth: _____

Address: _____
Street Apt#

_____
City State Zip code

Telephone Numbers: ( ) ____ - _____ (_____) ____ - _____

Please release my medical records from:

Name of Provider: _____

Provider's Address: _____
Street Apt#

_____
City State Zip code

To:

Name of Provider: _____

Provider's Address: _____
Street Apt#

_____
City State Zip code

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests and X-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____ _____
Patient's signature Date