THE FAMILY MEDICINE INSTITUTE

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Records Release Authorization

To: ________________________________

Attention: ____________________________

Phone: ____________________________

Fax: ____________________________

I hereby authorize the release of my personal Medical records/history to:

The Family Medicine Institute

Please forward all records in your possession to:
theinstitute@osteofamilydocs.com

From _____________ to _____________ TESTS / LABS / NOTES / ALL/
IMMUNIZATION RECORD

Name ______________________________DOB_________

Address _______________________________________

____

Signature ______________________________________

Date____

Witness _______________________________________