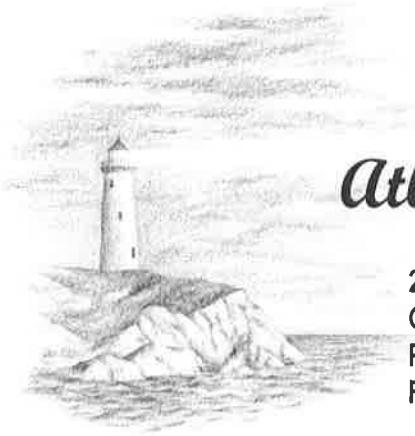

Atlantic Family Physicians

2 LEE AVE UNIT 103
GEORGETOWN, DE 19947
P. (302)856-4092
F. (302)856-4153

Patient Release of Medical Records Form
(Please Print or Type)

Patient's Name: _____ **request and give my permission to release my medical records for the time period dating from** _____ **to** _____ **from the follow medical office:**

Atlantic Family Physicians
2 Lee Ave Unit 103
Georgetown, DE 19947
(P) 302-856-4092
(F) 302-856-4153

The medical records as listed above are to be released to:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Fax Number:** _____

Comments: _____

If faxing or mailing the release of medical records form to the medical office, include a copy of a photo ID such as a state issued driver's license, state issued ID card, or Passport.

Type of ID presented: _____ **ID#**_____

Printed Patient Name: _____ **Date of Birth:** _____

Patient's Signature: _____ **Date:** _____