

# RELEASE OF MEDICAL RECORDS



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Patient Name: \_\_\_\_\_ DOB: (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Please release all medical records for treatment rendered to me during the period of:

(MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_

Please forward records to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

By signing below I authorize release of medical records to or from:  Dr. Sciacca  Dr. Davis

\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness*