HARDEE
Family Medicine
"Caring For Generations"
444 Williamson Rd, Suite E
Mooresville, NC 28117-9248
(704) 658-9779
(704) 658-9773 fax

Date: _____

Practice Name: _____

Office Number: _____ Fax Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Dear Doctor: _____:

The following individual has asked us to request that his or her medical records be released and forwarded to our office:
Patient Name: _____
DOB: _____ SSN: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file. Please be sure to include x-ray films and reports. Thank you for expedition this request. Please send these records to our office address shown above.

I herby authorize the release of all necessary medical records to Hardee Family Medicine. I wish them to be forwarded as soon as possible.

Patient's Signature: _____
Date: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Signature of Witness: _____ Date: _____