Authorization to Release Medical Records

Date _____

I, _____
patient's name

hereby request that my medical records be released to :

Gregory McNamara, DPM
33 Bartlett Street
Lowell, MA 01852

_____
patient's or guardian's signature relationship

_____
date of birth social security #

_____
patient's address

_____

_____

Please (circle one): FAX MAIL

Fax #: _____