MEDICAL RECORDS RELEASE FORM

To Whom It May Concern:

By this letter, I authorize release of my medical records to:

The Specialty Center for Physical Therapy and Sports Medicine
534 N 35th Street Suite D
Morehead City, NC 28557

I would like:

_____ All of my records

_____ Only the records pertaining to: _____

My full name is _____

My birthdate is _____

Thank you,

_____
(Patient, or Parent/Guardian Signature)