MEDICAL RECORD RELEASE

Patient Full Name (Printed): _____

Patient Date of Birth: _____

SEND INFORMATION TO:

Foothills Family Health & Wellness / Dr. Kinsey Shultz Piatz

Fax # (605) 719-7333

REQUESTING RECORDS FROM:

_____

(Medical Facility or Provider Name)

_____

(Facility Street Address)

_____

(City) (State) (Zip)

_____

(Phone) (Fax)

FOR CONTINUATION OF CARE, PLEASE PROVIDE ANY INFORMATION, INCLUDING DEMOGRAPHICS, DIAGNOSIS, LAB AND IMAGING REPORTS, AND RECORDS OF MY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE TIME PERIOD FROM _____ TO _____.

SIGNATURE _____ DATE _____