McCoy VISION

100A Providence Main Suite 1E, Huntsville, AL 35801
(256) 382-2700 Fax (256) 382-2705

Request for release of Medical Records

Date: _____

I hereby authorize and request that _____ release the complete history and records in their possession concerning my illness and /or treatment.

Please send records to the following address:

_____
Physician's Name

_____
Address

_____
City, State and Zip

_____
Print Patient Name Date of Birth

_____
Address City, State and Zip

_____
Patient/Guardian Signature Todays Date

This request is valid for 60 days from the date signed