KAKKIS MEDICAL GROUP, INC.

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____
Health Care Provider

_____
Street Address

_____, _____, _____
City State Zip Code

I hereby request that my medical records be **RELEASED TO:**

_____
Health Care Provider

_____
Street Address

_____, _____, _____
City State Zip Code

I understand that the entire medical record or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s) drug abuse, alcoholism, sickle cell anemia, acquired immunodeficiency syndrome (AIDS), or tests for or infection with human immunodeficiency virus (HIV); information about how my impairment(s) affects my ability to complete tasks and activities of daily living and/or my ability to work, will be provided unless I specify that the following information should not be released:

_____

_____

_____
Date

_____
Street Address

_____
Patient's Signature

_____
Print Name

_____
Social Security Number

_____
Date of Birth

_____
Last Seen