REQUEST FOR THE RELEASE OF MEDICAL RECORDS

Date: ________ ______ , ___________

To: ____

Address: _________________ .___________ _________________

City, State, Zip: ____________ ______ ________

I hereby request that my medical records be released to:

Richard D. Jelsma, MD 425
N. Highland, Ste. 110
Sherman, TX 75092
903-868-8800

Patient's Name: ____

Address: ____

City, State, Zip: _________________ ___________ : ________

DOB: ________________________ SSN: ________________________

Patient/Guardian Signature: __________________________________