PATIENT REQUEST FOR RECORDS

Date ______________________

To ____
(Doctor/Hospital)

Address____

City ____________________________ State _________ Zip ____________

I hearby authorize the release of my records or copies of such and request that they retransferred to:

Dr. James Myshka
114 S. College Ave., Suite A
Fayetteville, AR 72701

Print name of patient____

Patient's Signature ____

Date of Records ____