Dr. T. Mark Ricketts

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Medical Record Release Form

Please release a copy of my medical records TO / FROM (please circle one) Dr. T. Mark Ricketts. I understand that once the information is disclosed, this same information may be subject to redisclosure and may no longer be protected by law. I understand that I may revoke this authorization, in writing, to the appropriate parties involved.

Name ______________________ Date of Birth

Social Security Number ______________________ Authorization Expiration Date

Patient Signature ______________________ Date

Witness Signature ______________________ Date

Release TO / FROM (please circle one):

Name

Street Address / P.O. Box ______________________ City / State / Zip Code

Telephone Number ______________________ Fax Number