# Santa Barbara Doctor

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## Medical Records Release From our Facility

***From* whom I am requesting my records be released:**

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***To* whom I am requesting my records be released:**

**Medical Practice/Doctor Information**
Name: _____
Address: _____
_____
Phone: (_____)_____-_____
Fax: (_____)_____-_____

**Patient Information:**
Name: _____ Date of Birth / /
Address: _____
_____
Phone: (_____)_____-_____
Fax: (_____)_____-_____
Social Security #: _____/_____/_____

**Patient Signature:_____Date: ___/_____/_____**