

## MEDICAL RECORDS RELEASE FORM

To Whom It May Concern:

By this letter, I authorize release of my medical records to:

***The Specialty Center for Physical Therapy and Sports Medicine  
534 N 35<sup>th</sup> Street Suite D  
Morehead City, NC 28557***

I would like:

\_\_\_\_\_ All of my records

\_\_\_\_\_ Only the records pertaining to: \_\_\_\_\_

My full name is \_\_\_\_\_

My birthdate is \_\_\_\_\_

Thank you,

\_\_\_\_\_  
(Patient, or Parent/Guardian Signature)