rutland
FAMILY HEALTHCARE

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

_____

_____

_____

I hereby request that my medical records be released to:

RUTLAND FAMILY HEALTHCARE, LLC
5569 HOUSTON ROAD
MACON, GA 31216
(478)781-5065
(478)781-0012 FAX

Patient Name: _____

Address: _____

Contact No.: _____ Date of Birth: _____

_____ _____

Patient Signature Date