



188 Hospital Drive, Suite 304

Fairhope, AL 36532

Phone (251) 990-1950

Fax (251) 990-1951

Request for Records

Date: _____

Patient's Name: _____ D.O.B _____

Address: _____ Phone number _____

I hereby authorized:

Physician or Institution: _____

Address: _____

Phone number: _____ Fax number: _____

To release the following information (please circle)

All Records Discharge Summary History and Physical

Lab Reports Radiology Reports Operative Notes

Pathology Other (specify) _____

To Dr. Shoemaker, or designated representative, at the above contact information.

Signature of Patient or Guardian

Date

Witness

Date