

REQUEST FOR MEDICAL RECORDS

CONSENT TO RELEASE MEDICAL RECORDS

Date: _____

I, _____, hereby consent to allow Dr. Stokes to release and mail my medical records via the United State Postal Service. I understand there is a \$25 processing fee and am including a check made payable to Dr. Russell Stokes.

Sincerely,

(signature)

Please fill out the following information:

Approximate date of surgical procedure: _____

Any previously used names: _____

Address to mail records to: _____

Contact number: _____

Please mail form and check to:

Dr. Russell Stokes

P.O. Box 1473

Pinehurst, NC 28370-1473

Allow 2-3 weeks after mailing this request to receive your records.