**REQUEST FOR RELEASE OF MEDICAL RECORDS**

To: ______________________________

Physician/Practice Name

______________________________

Address

______________________________

City State Zip

I request my medical records be released to:

Alison Skurcenski, M.D.
Skurcenski Primary Care
645 North 12th St, Suite 300
Lemoyne, PA 17043
Fax: 717-296-0716

______________________________

Patient's Name (print) Birth Date

______________________________

Address

______________________________

City State Zip

Patient Signature: ______________________________ Date: ____________