Renovate Mental

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REQUEST FOR MEDICAL RECORDS

Today's Date: ______________________________

Patient Name: ______________________________ Patient Date of Birth: ______________________________

Patient Social Security Number: ______________________________ Date of Injury/Date(s) of Service: ______________________________

I hereby authorize and request you to release to **Renovate Mental, LLC** any and all medical records including but not limited to medical examination, treatment and services rendered pertaining to the above listed date and/or date(s) of service.

______________________________ ______________________________ ______________
PATIENT OR LEGAL GUARDIAN Full Name PATIENT OR LEGAL GUARDIAN Signature Date

______________________________ ______________
Client Signature Date