KRISTEN YEE, MD
PLASTIC & RECONSTRUCTIVE SURGERY

REQUEST FOR RELEASE OF MEDICAL RECORDS

ATTN: KRISTEN YEE, MD

PO BOX 650

WINDSOR, CA 95492

I hereby request copies of my medical records be released by

[ ] MAIL [ ] FAX

TO PATIENT/PHYSICIAN NAME: _____

ADDRESS _____

_____

PHONE (include area code) _____

FAX (if applicable) _____

RECORDS INCLUDED: ALL

PATIENT NAME: _____ **BIRTH DATE:** _____

_____ _____

Patient/ Representative Signature Date

Request is void if no signature is provided