MEDICAL RECORDS RELEASE

Date: ____

I hereby aurthorize ____

Physician's name

____

Physician's address

____

____

To release to MidAtlantic Urgent Care, LLC any information including diagnosis and records of any treatment or examination rendered to me.

The Records should be forwarded to:

MidAtlantic Urgent Care, LLC

3301 Wilson Blvd.

Arlington, VA 22201

Phone (703) 243-6720

Fax (703) 243-7503

____

Patient Name (Print)

____

Signature of Patient/ Power of Attorney/ Guardian

____

Patient Date of Birth

____

Patient Social Security Number