MEDICAL RECORDS RELEASE

Patient: _____ Date: _____

I hereby request that my complete medical records, including office notes, laboratory results, operations/hospitalizations, etc. be **forwarded** / **transferred to** / **from**:

_____

_____

_____

_____

To/from Dr. Paul Thomas at Hillside Gastroenterology & Nutrition, Inc.
250 Fame Avenue, Suite 240
Hanover, PA 17331
Fax: (717) 633-9379

Signature of Patient or parent/guardian: _____

Witness: _____

Date: _____ This release expires one year from this date.
Records should be forwarded within 30 days.