

▲ REQUEST FOR RELEASE OF MEDICAL RECORDS

I HEREBY REQUEST THAT MY RECORDS BE RELEASED FROM:

STEPHEN R. WELLS, M.D.
110 Tampico, Suite 220
Walnut Creek, CA 94598
(925) 935-5356
(925) 935-1070

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE SENT TO:

Self/Dr. : _____

Address: _____

City, State, Zip: _____

Patient's Name: _____
(PLEASE PRINT)

Patient's Signature: _____

Date of Birth: _____

A \$20.00 records copy fee will apply. Payment must be received with this request prior to your records being sent.

A 10 day notice is required or an additional fee of \$5.00 applies for a RUSH request.

I authorize Dr. STEPHEN R. WELLS, M.D. to charge my credit card for \$_____.

Amex/Visa/Master Card number _____ exp date: _____

Signature: _____ Date: _____

RECORDS WILL NOT BE SENT WITHOUT PAYMENT