

**Robert D. Gordon, MD**

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**Patient Record Release**

I \_\_\_\_\_ request that my medical record be mailed to me at the below address. By signing this release I am assuming all responsibility for the hard copy of my medical record.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\* This form must include a \$6 check or money order for mailing costs.**