



Raymond Zhou, M.D., P.C.

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AUTHORIZATION OF RECORD RELEASE

Last Name : _____, First Name: _____, Date of Birth _____

Address: _____

Authorization and request is hereby made for my medical record to: release from; receive

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Shrewsbury MA, 01545

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Physician Name: _____, Phone# _____ Fax _____

Address: _____

The following information is requested:

- | | |
|---|---|
| <input type="checkbox"/> Physical Exam | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Medication records |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Occupational health |
| <input type="checkbox"/> X-ray | <input type="checkbox"/> Worker injury reports |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Physical therapy reports |
| <input type="checkbox"/> Pulmonary Function Testing | <input type="checkbox"/> Immunization records |
| <input type="checkbox"/> Other specific Progress Notes: _____ | |

Does this include psychiatric, chemical dependency and/or Aids-related information?

- YES NO
- Specific for Psychiatry Consultation Notes
- Specific for drug testing results

Signature of Patient or Legal Representative Date

(IF NOT SIGNED BY PATIENT, SPECIFY RELATIONSHIP TO PATIENT)