CHRISTOPHER N. SPELLMAN M.D., INC.
169 Saxony Rd. Suite 115
Encinitas, CA 92024
Phone: (760) 633-3377
Fax: (760) 633-3370

MEDICAL RECORDS RELEASE FORM

Patient Name: _____

Patient Date of Birth: _____

I, the patient, request that my complete medical records be sent to:
Please select one:

- ☐ **Christopher N. Spellman M.D., Inc.**
  169 Saxony Rd. Suite 115
  Encinitas, CA 92024
  Fax: 760-633-3370
- ☐ **To myself, or my legal representative:**
  Name:_____
  Address:_____
  _____
  Phone:_____
  Fax:_____
- ☐ **The office indicated below:**
  Office Name:_____
  Address:_____
  _____
  Phone: _____
  Fax:_____

Signature of Patient or Legal Representative:

X_____ **Date:**_____

Note: It takes about 1-2 weeks for the doctor to look over the notes. We will call you when the records are ready to be picked up. Thank you for your time and cooperation.