



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

415 Boston Turnpike, Suite 105  
Shrewsbury, MA 01545  
Phone: (508) 845-8200  
Fax: (508) 845-8300

## 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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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)