Mertz MFM Center

PATIENT NAME: _____
PATIENT ADDRESS: _____
CITY, STATE, ZIP CODE: _____
DOB: _____
PHONE: _____

**RE: Release of medical records for patient:**

I authorize _____ to release all medical records related to my treatment rendered from the period of _____ through _____. This information will be used to further assist in my medical care, and should be mailed, faxed, or emailed to:

Heather L. Mertz, MD
Mertz MFM Center
3815 Forrestgate Drive
Winston Salem, NC 27103
Phone: (336) 930-9600
Fax: (336) 930-9930
Email: frontdesk@mertzmfm.com

PATIENT SIGNATURE: _____

DATE OF REQUEST: _____