

The Metropolitan Women's Group, LLC

Dr. Kimberly Campbell-Arrendell ~ Dr. Yolande Hackney ~ Dr. Leslie Simmons

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1111 Spring Street, Suite 220 • Silver Spring, MD 20910

Medical Records Release Form

Date: _____

To: _____

I, _____, hereby authorize _____
(Name of Patient) (Name of Former Practice/Physician)

to transfer a copy of my medical records to one of the following physicians listed below. Please send my records to the above referenced address.

____ Kimberly Campbell-Arrendell, M.D.

____ Yolande Hackney, M.D.

____ Leslie Simmons, M.D.

Signature of Patient: _____

Print Name: _____

Date of Birth: _____

Social Security #: _____