Patient Records Request Form

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I hereby request a copy of my medical record as detailed below:

Full medical record held by this office

Medical record for the period _________________through_______________________

A specific portion/section of the record as follow:

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Name: _____________________________________

Date of Birth: ________________________________

Sent to:

Name: ____

Address: ____

Please mail or fax this request to the above address or fax number.

Thank you.