Patient Records Request Form

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Name of Patient Whose Record is Requested _____

Date of Birth _____**Phone** _____

Address _____

City/State/Zip _____

Please provide a copy of the record maintained by the provider/practice

☐ **The full health record maintained by this provider/practice**

☐ **The Health record for the following time frame:** _____ **through:** _____

☐ **A specific section of the health record as described below:** _____

_____

_____

Signature of Patient _____

Signature of Authorized Personal Representative _____

Relationship to Patient _____

Date _____