Family Health Care Associates

Medical Records Request Form

I AM REQUESTING A COPY OF MY MEDICAL RECORDS. I UNDERSTAND THAT IT MAY TAKE UP TO 30 DAYS BY LAW TO RECEIVE MY FREE COPY. I WILL BE NOTIFIED VIA PHONE WHEN MY RECORDS ARE AVAILBLE FOR PICK UP.

DATE: _____

PATIENT NAME FOR RECORDS: _____

DOB: _____ SS#_____

PHONE: _____

MAILING ADDRESS: _____

TYPE OF RECORDS BEING REQUESTED:_____

_____

PATIENT/GUARDIAN SIGNATURE: _____

MY SIGNATURE VERIFIES THAT I HAVE RECEIVED A COPY OF MY MEDICAL RECORDS AS REQUESTED.

PATIENT/GUARDIAN SIGNATURE: _____

WITNESS: _____

OFFICE MANAGER: _____