Patient Medical Records Request Form

Patient Information

Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email Address: _____

Request Details

Records Requested:

☐ Complete Medical History

☐ Lab Results

☐ Imaging Reports

☐ Prescriptions

☐ Other (Specify): _____

Time Period for Records:

From: _____ To:

_____

Delivery Method

☐ Email: _____

☐ Physical Copies (Mailing Address): _____

☐ Pick-Up at Facility

Authorization

I, _____ (Full Name), authorize the release of my medical records as specified above to the provided contact details.

Signature: _____ Date: _____