PCP PRIMARY CARE PARTNERS

REQUEST TO COPY PROTECTED HEALTH INFORMATION

Patient Name: _____

Acct #: _____

Date of Birth: _____

Patient/Parent Phone Number: _____

Patient Address: _____
Street

_____
Apartment #

_____
City, State, Zip

FOR INTERNAL PURPOSES ONLY:

Send medical record to (if different from above):

_____
Name

_____
Street

_____
City, State, Zip

Reason for request _____

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

Instructions for Medical Records Requests

Please return the completed form to our office. Note that there may be a charge for copies per state Medical Society guidelines. If so, a staff member will contact you to review any charges.