FAMILY MEDICAL GROUP, P.A.

MEDICAL RECORDS REQUEST

Patient Name: ______________________________
Date of Birth: ___________
Contact Phone Number: ____________

I authorize Orange Family Medical Group to
RELEASE or OBTAIN (please circle one) information to/from:
Name of Provider: ______________________________
Name of Facility: ______________________________
Street Address: ______________________________
City, State, Zip Code: ______________________________
Phone Number: ______________________________
Fax Number: ______________________________

Information to be released/obtained (check appropriate boxes):

- ☐ Comprehensive report
- ☐ Office visit notes
- ☐ Laboratory reports
- ☐ Immunization records
- ☐ Radiology reports
- ☐ Operative reports/Procedure notes

Other: ________________

Patient or Guardian Signature: __________________________

Patient or Guardian Printed name: ________________________

Date: ____________

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