Patient Record Request Form

Date: _____

To:

Medical Records Department

[Hospital/Clinic Name]

[Address]

[City, State, Zip]

From:

Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email: _____

Request Details:

Please release copies of my medical records for the following dates of service:

From: _____

To: _____

Purpose of Request:

_____

Signature:

_____

(Patient's Signature)

Please contact me at the above phone number or email for any questions regarding this request.

Thank you.