Medical Records Request Form

Patient's Name: ____

Date Of Birth: ____/____/____ Social Security Number: _____-_____-______ Phone #: (_____)_____-______

Address: ____

____

PLEASE RELEASE MY MEDICAL RECORDS TO:

Provider's Name: ____

Address: ____

____

Phone #: (_____)______________ Fax #: (_____)_______________ E-mail: ___________________________

FROM: Dr. Peter A. Thomas & Associates, LLC
4700 S Flamingo RD, Cooper City, FL 33330
Phone: (954) 252-9191
Fax: (954) 204-3731

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

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

____ ____
Signature of patient, guardian, or personal representative Date

____ ____
Please print name of patient, guardian or personal representative Relationship to patient

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