Crabapple Medical Center PC

PRIMARY CARE & GERIATRICS

Care with Compassion

Release of Medical Records

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ - _____ - _____ Phone Number: (____) ____ - _____

Date Requested: _____ / _____ / _____

Reason: _____

Requested By: [ ] Patient [ ] Physician [ ] Other _____

Please Disclose Records To:

Practice Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (____) ____ - _____

Documents Included:

- ☐ All Medical Records
- ☐ Clinic Notes
- ☐ Office Visit Notes
- ☐ History & Physical
- ☐ Radiology Reports
- ☐ Lab Reports
- ☐ Pathology Reports
- ☐ Urgent Care
- ☐ Nurse Notes
- ☐ EKG
- ☐ Physician Orders
- ☐ Other _____