Today's Date:______________

Medical Records Release Form

Please fax to 586-221-4614 or send electronic

copies only. No mailed paper records.

I____D.O.B________________

Hereby authorize the Complete Family Care physicians to retrieve all of the requested medical history contained in my patient medical record from the following physician:

____

Physician/Facility Name: Address

____

Office Phone **Office Fax**

I am requesting the following records:(Please Circle What Applies)

- **My Entire Medical Record**
- **Medical Records for the following dates:_____________________________**
- **Other Medical Testing Reports or Procedures:_________________________**
- **____**

Patient Signature or Legal Guardian Signature:

____Date:____________________