Medical Records Request Form

Patient Name: ____

Date of Birth: ____________________ Phone: ______________________

______________________, hereby give consent for Metropolitan OB/GYN, PA
(Patient Name)

to receive my medical records & any information from the doctors' office below:

Office or Institution: ______________________________________

Contact: ______________________________________

Address of office or hospital: ______________________________________

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Telephone Number: ______________________________________

Fax Number: ______________________________________

Dates of service from this office/hospital: ____________________________

What records/results needed: ______________________________________

I give consent for my medical records to be sent by fax or by mail to Metropolitan OB/GYN and I understand that my privacy will be protected and only those records that have been requested will be released.

______________________________________ ____________________

Signature of Patient Today's Date