Visalia Women's Specialty Medical Group, Inc.

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REQUEST FOR ACCESS TO MEDICAL RECORDS

PATIENT NAME _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ PHONE: _____

I hereby authorize: _____

_____

to provide copies of my medical records to: _____
Name of Doctor/Medical Provider/Clinic

ADDRESS: _____

_____

DATE OF TREATMENT: From: _____ To: _____

Mail Record: _____ Pick up record: _____ F ax: _____

PURPOSE OF DISCLOSURE _____ Medical Care _____ Personal

Records requested by:

NAME _____

SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT: _____