Primary Care Partners
Affiliated with
Atlantic Health System

_____

CARE CENTER NAME

REQUEST TO COPY PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Patient Address: _____
Address 1

_____
Address 2

_____
City, State, Zip

Send medical record to (if different from above):

_____
Name

_____
Street

_____
City, State, Zip

Reason for request:_____

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

_____ _____
(Signature of Patient or Legal Guardian) Date

_____
Print Name of Patient or Legal Guardian

Instructions for Medical Records Requests

Please mail the completed form to our office. Note that there may be a charge for copies per state Medical Society guidelines. If so, a staff member will contact you to review any charges.