PHONE: 334-654-5080

ANDERSON FAMILY CARE

FAX: 334-654-5081

Patient Request for Health Information

Patient Information

_____

First Name Middle Name Last Name

Address _____ City_____ State_____ Zip _____

Date of Birth _____ Phone _____

_____ **I request that the following organization provide my health information to Anderson Family Care:**

Name_____

Address _____ City _____ State_____ Zip _____

Phone _____ Fax _____

Release records from the following dates: _____ to _____

_____ **I request that Anderson Family Care provide my health information to:**

Name_____

Address _____ City _____ State_____ Zip _____

Phone _____ Fax _____

Release records from the following dates: _____ to _____

Release the following records:

_____ Entire Record/All _____ Labs _____ Immunizations _____ Images _____ Office Notes

_____ Other (specify): _____

Signature of Patient: _____ Date: _____

Signature of Representative: _____ Relationship to Patient: _____

A processing fee may be applied.