Sugarloaf Medical P.C.

General Internal Medicine – Primary Care

Medical Records Request Form

Patient Name: _____ Date of Birth ____ / ___ / _____
Last First Middle

Address _____
Street City State Zip

What type of medical records do you need? (Check one below)

□ Entire Medical Records

□ Other: _____

I, the signed patient or legal guardian of patient authorize Sugarloaf Medical PC to release my records to:

_____
(Name of Physician, Medical Practice, or Treating Hospital)

_____
(Address of Facility) (City) (State) (Zip)

_____
(Telephone #) (Fax # - Very Important)

By: □ Fax □ Mail □ Patient will pick up the records at our office

_____
Signature of Patient or Legal Guardian Date of Birth Social Security Number

_____
Print Name of Patient or Legal Guardian Date