REQUEST FOR MEDICAL RECORDS

Patient Name: ____

Date of Birth: _______________________

Phone #: ___________________________

Email Address: ____

Address: ____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: ____

Phone #:___________________________

METHOD OF DISCLOSURE:

Fax #: _____________________________

Email Address: (please note that emailing may not be a secured method of communication)

____

INFORMATION TO BE DISCLOSED: (Check Selection)

_____General Medical Record(s),

_____Progress Notes

_____History and Testing

_____Other: (specify)____

Client/Legal Representative Signature:_____________________________Date:____________

Printed Name:____

Legal Representative's Relationship to Patient:_______________________________________

All requests will be filled within 30 calendar days. All records more than 25 pages will be sent electronically. Please provide a valid email address.

FLMTC HOLDINGS, LLC
12040 South Jog Road, Suite 7, Boynton Beach, FL 33437
P 561.510.7136 **F** 561.510.7152 **E** info@flmtc.com **W** www.flmtc.com