Please **ONLY** complete "Patient Name, Date of Birth, Social security #, Patient Signature, and today's date". By leaving the receiving office information blank, it allows our office to complete the form with all of your doctors or specialist information without you having to complete multiple medical record request forms.

Allegra Family Clinic Home Based Primary Care

Patient Request of Medical Records

1116 Mitt Lary Rd
Northport, AL 35475

Office#(205)556-5634
Fax#(205)615-3050

Office Name:____

Physician Name:____

Office Address:____

City:____ **State:**________ **Zip:**__________

Office #:(______)______-________ **Office Fax #:**(______)______-________

The patient has requested and given consent to release any medical records from the provider listed above to their Primary Care Physician.

Patient Name:____

Patient Date of Birth:____/____/________ **Last 4 #s of Social Security #:**________

Patient's Signature:____

Today's Date:____/____/________