Premier
HEALTH • WELLNESS • URGENT CARE

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____
(Physician Name)

_____
(Address)

_____
(City) (State) (Zip)

_____ / _____
(Phone) (Fax)

I hereby request that my medical records be released to:

Premier Family Health, PA
1037 S State Road 7, Suite 211
Wellington, Florida 33414
Office: (561) 798-3030
Fax: (561) 798-8242

FROM: _____
(Patient's Name)

_____
(Patient's Signature) (Date)

_____ / _____
(Date of Birth) (Social Security Number)