PATH HOUSE MEDICAL PRACTICE

I, ____ (Name)

Of ____ (Address)

____

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D.O.B _____________________

I request copies of my Primary Care Medical Records as below: -

☐ Please provide me with copies of my FULL Medical Records

☐ Please provide me with a partial copy of my Medical Records

from ___________________ until ______________________

☐ Other (***state specifically and clearly what you require***)

Signed by Patient __________________________________

Date ___________________