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PATH HOUSE MEDICAL PRACTICE

I, _____ (Name)

Of _____ (Address)

_____

_____

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 _____