Print Form

Accent on Health Ob/Gyn, P.C.

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PATIENT REQUEST FOR MEDICAL RECORDS

I hereby request and authorize you to release my medical records.

Send To :

Name:					
Phone:		**Fax:**			
Address 1:					
Address 2:					
City:		**State:**	New York	**Zip:**	

Requested By Patient:

Last Name:					
First Name:		**DOB:**			
Phone:		**Fax:**			
Address 1:					
Address 2:					
City:		**State:**	New York	**Zip:**	
Signature:		**Date:**			

☐ **Please check box if you are leaving our practice.**

Provider		**Date:**	

If pt is leaving the practice: cancel all future appointments and change status to Inactive. Scan and attach to Pt chart after Responsible Provider signature.