MEDICAL RECORDS REQUEST Date:_____

Type of Records: _____

Physician/Facility Name

_____

Address

_____

City State Zip

_____

Fax Phone Email

_____

I hereby request my medical records be released to:

Victoria Herold, DO at Clover Family Medicine

255 West Lebanon Rd, Suite 106, Frisco, TX 75036

Fax: 1(877)370-4339 **Phone:** (469)294-0210 **Email**: info@cloverfamilymedicine.com

Patient's Name (print) Birthday MM/DD/YYYY

_____

Address

_____

City State Zip

_____

Phone number Fax number

_____

Email

_____

Signature: _____ Date: _____