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

1125 Legacy Dr Ste# 220 Frisco, TX 75034

Fax: (469)548-7525 **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: _______________________________