TEXAS FAMILY WELLNESS CLINIC

MEDICAL RECORD REQUEST

Date Requested: ___/____/____

Requesting Medical Records from: _____

Phone #: _____ Fax #: _____

Please forward the following:

___ Last 5 Progress Notes
___ Most Recent Labs
___ Imaging
___ Cardiac Test Results

Patient's Name: _____

Address: _____

_____

Date of Birth: ____/____/_____

Patient's Signature: _____

Forward all records to -
Texas Family Wellness Clinic
% Ron Guevara, D.O.
15406 Northwest Blvd., Ste. B
Robstown, TX 78380

SECURE EMR/MEDICAL RECORDS FAX LINE: 800-990-5305
We also accept records via eClinicalWorks with P2P