Golden Isles
Partners In Health

MEDICAL RECORDS REQUEST

To: Dr. ____

Address: ____

____

____

Tele: _____- _____ - _______ Fax: _____- _____ - _______

- ○ All medical treatment From (date)_____________ To (date)______________
- ○ Laboratory tests
- ○ Specific treatment

The purpose for requesting my medical records: ____

I hereby authorize the release of my medical records of copies of such and request that they are transferred to:

Golden Isles Partners
In Health, LLC
118 Northpark
Brunswick, GA 31520-2111
912-268-4994 office
912-434-9096 fax

Patient name: ________________________________ Date: ____________________

Patient DOB: ________________________________
Date of Records: From: __ / ___ / ______ to __ / ___ / _______

Patient signature: ____