

MULTICARE

Sent by: _____ DATE: _____ Time: _____

Health Center
3842-44 Harlem Ave.
Lyons, IL 60534

Phone: 708.442.3050 **2nd Attempt: Date:**
Fax: 708.442.3058 **3rd Attempt: Date:**

Time:
Time:

PATIENT REQUEST FOR RECORDS

Date: _____

Facility/Hospital Name: _____

Attention: **Medical Records Department**

Address: _____

City: _____ State: _____ Zip: _____

PHONE: () _____ FAX: () _____

Description _____

I _____ hereby authorize the release of my medical records or copies of such and request that they are **FAXED** directly to:

Multicare Health Center

3842-44 Harlem Ave.
Lyons, IL 60534
Phone: 708.442.3050
Fax: 708.442.3058

Please print Patient's Name

Patient's Date of Birth

Patient's Signature

Note: The information contained in this facsimile may be privileged and confidential and protected from disclosure. If the reader of this facsimile is not the intended recipient, you are hereby notified that any reading, dissemination, distribution, copying, or other use of this facsimile is strictly prohibited. If you received this facsimile in error, please notify the sender immediately by telephone at 708.442.3050 and destroy this facsimile. Thank you.