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

Sent by:_____ DATE: Time:

Phone: 708.442.3050
Fax: 708.442.3058

2nd Attempt: Date: **Time:**

3rd Attempt: Date: **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