4611 Okeechobee Blvd. Suite 110, West Palm Beach, FL 33417
Phone: (561) 408-9444 Fax: (561) 689-7500

REQUEST FOR MEDICAL RECORDS

Patient Name:_____

DOB: _____

Please check one:

☐ **Please obtain my medical records from the following address**

☐ **Please transfer my medical records to the following address**

☐ **I do not wish for my medical records to be released to BMHC**

☐ **I do not have any previous medical records for BMHC to obtain**

Physician/Facility:_____

Address:_____

City: _____ State:_____ Zip Code:_____

Phone: _____ Fax: _____

Patient Signature:_____ Date:_____