pacific frontier
MEDICAL

Patient Medical Records Request Form

Patient Information:

First Name:_____ Initial:_____

Last Name:_____

DOB:_____

Requesting that Records be sent to: _____

_____

_____

OR

Requesting records be faxed to: _____

I, _____ (person responsible for payment), understand there is a fee for this services. I authorize Pacific Frontier Medical, Inc. to provide medical records for _____ (Patient's Name) to the address or fax number supplied above.

Signature:_____ Date:_____

1098 Foster City Blvd. Suite 305 Foster City, CA 94404
Phone: 650-474-2130 Fax: 650-445-0912

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