MedCare
Request for Medical Records

TO: _____

_____

Patient Name: _____

Address: _____
Street City State Zip

Phone #: _____

Date of Birth: _____

SSN: _____

I am requesting a complete copy of my Medical Records that you hold in your possession be mailed or faxed to the following:

Fax: 706-324-5233

Mailing Address: MedCare
5612 Whitesville Rd
Columbus, GA 31904

_____ _____
Signature of Patient Date Witness-MedCare Staff Date