HEALTH First
MEDICAL CENTER
Syed F. Hussain M.D.

REQUEST FOR MEDICAL RECORDS

Patient Name_____

Date of Birth _____/_____/_____ SS# _____-_____-_____

Address_____

City_____ State_____ Zip_____

The above mentioned patient has requested that a copy of:

_____ Complete Medical Record

_____ Radiology Reports

_____ Lab Reports

_____ Hospital Records

_____ Other: _____

From:_____
Facility or Physicians Name

Address_____

City_____ State_____ Zip_____

Phone_____ Fax_____

Be released to Syed F. Hussain M.D.

_____ _____
Patient Signature Date