CREDO
FAMILY MEDICINE

Medical Records Request Form

Patient Full Name: _____

Address: _____

Phone Number: (____)_____ Date of Birth: _____/_____/_____

I, _____, (Patient/Guardian) hereby grant permission for:

Clinic Name/Physician to Be Requested: _____

Address: _____

Fax Number: (_____)_____ to release my health information to:

Credo Family Medicine
10050 Auburn Park Dr.
Fort Wayne, IN 46825
Phone: (260) 432-6459 / Fax: (260) 240-5284

For office use only

- ☐ Hospital Notes **Last year**
- ☐ Emergency Reports
- ☐ Office Notes **Last 2 notes**
- ☐ Lab Results **Last year**
- ☐ Imaging and Other Test Results **All**
- ☐ Nursing Home/Home Health/Hospice/Other Physician Records
- ☐ Financial History Report
- ☐ Other:

Purpose of release of information: **Transfer of care**

I understand that this authorization may remain valid for 1 year post signing of this document. I further understand that I may revoke this authorization by writing to the contact for Credo Family Medicine at any time, except to the extent that this authorization has already been exercised. Credo Family Medicine cannot refuse me treatment based on my refusal to sign this form. I also hereby hold harmless the releasing party from any legal liability that arises from the release of my health information.

I hereby grant permission for Credo Family Medicine to keep a copy of my medical records for their own records.

Patient/Guardian Signature: _____

Printed Name: _____

Relationship to Patient: _____ Date: _____/_____/_____