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### MEDICAL RECORDS REQUEST

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

To Whom It May Concern, Date: \_\_\_\_\_

Please release a copy of my medical records, especially records regarding the following:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TO: Fair Oaks Women's Health  
625 S. Fair Oaks Ave.  
Suite 255, South Lobby  
Pasadena, CA 91105-2651  
(626) 304-2626  
Attention: Medical Records Dept.

Thank you very much,

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Signature

Printed Name

Date

Note: use this form to request that an outside doctor, clinic or hospital send copies of your medical records to us