

**INTERNAL MEDICINE & PEDIATRIC CLINIC
OF NEW ALBANY, PLLC**

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Phone: 662-534-0898 Fax: 662-534-8905*

Request for Medical Records

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOC. SEC. NO.: _____

DATE OF BIRTH: _____

PHONE: _____

MEDICAL INFORMATION OR RECORDS BEING REQUESTED:

FOR THE PURPOSE OF:

NAME AND ADDRESS TO WHOM INFORMATION NEEDS TO BE SENT:

NAME OF CLINIC OR DOCTOR INFORMATION IS BEING REQUESTED FROM
AND ADDRESS AND PHONE NUMBER OF DOCTOR OR CLINIC:

Signature of Patient or Legal Representative

Date