DELIGHT PRIMARY CARE
PROVIDING VALUE BASED MEDICINE

Request of Release for Medical Records

1) PATIENT INFORMATION:

_____

Name *Address* *City* *State* *Zip*

_ _ / _ _ / _ _ _ _ (_ _ _) _____ _____

Date of Birth *Daytime Phone* *Previous Name (if Applicable)*

2) AUTHORIZES:

_____

Name of Health Care Provider / Plan / Other

_____

Address

3) TO DISCLOSE TO:

DelightPrimary Care/Dr. Degha Fongod _____

Name of Health Care Provider / Plan / Other

3022 Javier Road, Suite105E, Fairfax **765-780-4526**

Address *Fax Number*

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____/_____ to _____/_____ If left blank, information from the past two (2) years is requested. *(Month/year) (Month/year)*

5) INFORMATION TO BE DISCLOSED:

All medical records related to (specify condition, treatment, etc.): _____

All medical records: Radiology films/images (specify test) _____

Specific records/information as follows: _____

_____

_____

6) PURPOSE: Further Medical Care

SIGNATURE OF PATIENT / LEGAL REP: _____ DATE: _____