Medical Records Request Form

FCAP ID: _____ DOB: _____

Release to Obtain Information Sent ☐ Court Order Sent ☐

Date Sent: _____ Date Received: _____

Medical Provider: _____

_____

_____

Telephone Number: _____

Fax Number: _____

Notes:

FCAP ID: _____ DOB: _____

Release to Obtain Information Sent ☐ Court Order Sent ☐

Date Sent: _____ Date Received: _____

Medical Provider: _____

_____

_____

Telephone Number: _____

Fax Number: _____

Notes: