



PRIME CARE
FAMILY PRACTICE

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ Date of Birth: _____

Physician/Entity: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

I hereby request that my medical records be released to:

Maryline Ongangi, FNP

Lewis Nyantika, FNP

Dr. Eberechi Anozie

1001 N. Waldrop Dr., Ste 801

Arlington, TX 76012

Phone: 817-962-0056

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*****Secure email: patientcare@primecarefp.com*** (preferred method)**

Signature

Printed Name

Date

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Phone
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