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
Fax: 817-962-0057
*****Secure email: patientcare@primecarefp.com*** (preferred method)**

_____ _____
Signature of Parent/Guardian of Minor Patient Date

_____ _____
Printed Name Relationship to Patient