Galatians
Community Health

RECORDS REQUEST FORM

(Referral / Transfer of Care due to Practice Closure)

PATIENT INFORMATION:	Name:	
	Address:	
	Phone:	Date of Birth:

RECORDS REQUESTED FROM:	***GALATIANS COMMUNITY HEALTH*** *1004 Dresser Ct, Ste 102, Raleigh, NC 27609* *FAX: 213-516-8578*

I consent and authorize Galatians Community Health to release copies of my medical records as follows for the purpose of continued patient care due to the closure of the practice:

- ☐ ALL of my medical records
- ☐ ONLY send records from (Date) _____/_____/_____ to (Date) _____/_____/_____
- ☐ Only send specified records as explained below:

_____

SEND RECORDS TO:	**Provider / Facility Name:**	
	Address:	
	Phone:	**Fax:**

I understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken. This consent will automatically expire one year from the date on which it is signed.

SIGNATURE: *(Signature of Patient, Parent, Legal Guardian)*	***PRINT NAME:***	***DATE:***
	Signature:	

RETURN INSTRUCTIONS: Please complete, sign & FAX this form to:213-516-8578