



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: 919-556-6099

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: 919-556-6099