First Care

HEALTH CENTER

Name: _____ Date of Birth: _____

I am requesting my personal medical records from First Care Health Center for the following condition/dates of service: _____

_____

Method of delivery: Pickup at First Care Health Center _____

Submit by mail to: _____

_____

_____

Other method of delivery: _____(specify)

I request that my results be sent via email. I understand that this method of delivery is not secure.

EMAIL Address _____

_____ _____

Patient Signature Date

Request Completed _____ (Initials)