

ALL LINES MUST BE COMPLETED TO PROCESS REQUEST

**Family Medical Group
911 E. Tuolumne Road
Turlock, CA 95382
(209) 668-4101**

MEDICAL RECORDS REQUEST

TO:

Name of Physician/Provider



Street Address

City State Zip

Records to be sent to:

**Family Medical Group
911 E. Tuolumne Road
Turlock, CA 95382
(209) 668-4101
(209) 668-3758 Fax**

*******PLEASE INDICATE WHICH DOCTOR THE RECORDS ARE TO BE SENT:*******

Thomas I. Wilson, M.D. James C. MacLaren, M.D. Scott C. Hennes, M.D.
 James C. Knapp, M.D.  

I hereby authorize you to send a copy of my medical records to the above.
Please include:

_____ All medical records
_____ Only those medical records pertaining to _____
_____ All medical records except those pertaining to _____

Name _____ Signature _____

Birthdate _____ Date _____

Social Security # _____ Witness _____

THIS REQUEST EXPIRES 60 DAYS FROM THE SIGNED DATE