

REQUEST FOR MEDICAL RECORDS

I request a copy of my medical records be sent to :

DR. Keith A. Williams

at

Advanced Rehabilitation Medical Services Inc.

4265 Laura Street

Charlotte Harbor, Florida 33980

Tel. 941.764.7117

Fax 941.764.1049

MEDICAL RECORDS REQUESTED FROM:

(Physician or Provider Name)

(Address)

TO USE FOR: _____

Print Patient's name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____ Zip: _____

Date patient was last seen by Physician in the records _____

PATIENT'S SIGNATURE: _____

Date: _____

DATE RECORDS REQUIRED BY: _____

REQUESTED RECEIVED BY: _____ DATE: _____

DOCUMENTS SENT BY: _____ DATE: _____