DR ANNETTE BEAUFILS
Provider No 0455545T

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PATIENT REQUEST FOR DIGITAL COPY OF THEIR MEDICAL RECORDS

PATIENT NAME:

ADDRESS:

DATE OF BIRTH:

PHONE NUMBER:

I hereby request a copy of my records for future use upon Dr Beaufils retirement and the closure of her medical practice.

Signature…….. Date requested……...

Other family members included on this release are:

NAME	SIGNATURE IF OVER 18

I have received a copy of my complete medical record on USB from Dr Annette Beaufils.

Signature: …… Date: ……...