SCCHC Medical Record #_____

South Cove Community Health Center

Request to Obtain Health Information from Other Health Care Provider

Patient Name (First, Middle, Last)	Date of Birth
Address	
City/State/Zip Code	Telephone #

_____ This patient does not have a PCP

_____ This patient declines to provide PCP's contact information and/or declines to release medical record to South Cove.

_____ _____

Patient's Signature Date

_____ _____

Signature of Legal Representative Date