KHATIB
FAMILY PRACTICE

Records Request Authorization

Please provide details of any **physicians you have seen in the past** whose records we may request on your behalf. This will help your doctor better understand your **medical history and previous treatments**.

Physician Information

Physician 1

- **Physician Name:** _____
- **Specialty:** _____
- **Address:** _____
- **City:** _____ **Zip Code:** _____
- **Phone:** _____ **Fax:** _____

Physician 2

- **Physician Name:** _____
- **Specialty:** _____
- **Address:** _____
- **City:** _____ **Zip Code:** _____
- **Phone:** _____ **Fax:** _____

Physician 3

- **Physician Name:** _____
- **Specialty:** _____
- **Address:** _____
- **City:** _____ **Zip Code:** _____
- **Phone:** _____ **Fax:** _____

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Patient Authorization & Signature

I authorize the release of my medical records from the physicians listed above to my current healthcare provider for continuity of care.

- **Patient Name: _____**
- **Date of Birth (DOB): _____**
- **Patient Signature: _____**
- **Date: _____**
