



REQUEST FOR TRANSMISSION OF MEDICAL RECORD

Patient Name: _____ Date: _____

Date of Birth: _____

Name and address of current Physician:

Name of Physician

Address

City

State

Zip Code

Office Phone Number

Please be advised that I have given permission to Dr. Robert M. Grife and representatives of MYCARE PHC, LLC to request and receive my complete medical record from your office.

Please forward my medical record to MYCARE PHC c/o Dr. Robert M. Grife at:

9 Marigold Court
Lumberton, NJ 08048

Or

Fax it to Dr. Grife at (978) 709-8408

Please feel free to contact Dr. Grife at 609-509-3445 with any questions or concerns.

Thank you in advance for your timely attention to this matter.

Sincerely,

Patient Signature