Patient Request To Have Medical Records Transferred to Another Health Care Provider

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email Address: _____

I am writing to request copies of my medical records from Family Medical Center at Cinco Ranch for the purpose of continuation of medical care.

My treatment dates are from: _____ to: _____

All treatment dates through 10/7/2024: check this box ☐

Send my records to Memorial Hermann Medical Group:

Name Of Provider: Shelley C. Ferrill, MD

Send the following items.

☐ Complete Medical Record	☐ Emergency Room	☒ Radiology Reports
☐ Abstract/Pertinent	☒ History & Physical	☐ Cardiac Studies
☐ Operative/Procedure Report	☒ Lab	☐ Consultation Reports
☐ Discharge Summary	☐ Coding summary	☐ Other:_____

Patient / Guardian Signature	Print Name	Relationship to patient	Date	Time ☐ AM ☐ PM

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