

Linda Boarman FNP

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PHILPOT, KY 42366
270-713-0177 (phone)
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Request for Release of Medical Records FROM:

Physician/Facility_____

Address_____

City_____State_____Zip_____

All records Pertaining to: _____

Physician/Facility_____

Address_____

City_____State_____Zip_____

All records Pertaining to: _____

Physician/Facility_____

Address_____

City_____State_____Zip_____

All records Pertaining to: _____

I hereby request a copy of my medical records be released TO:

Linda Boarman, FNP

X _____ **X**
Patient/Guardian/Representative Signature Date

(Printed Name)

Date of birth: _____ Last 4 of SSN: _____