MILLENNIUM MEDICAL CARE

*Your Health is Your Wealth*

# Request Medical Records from other Medical Facilities

To: Company Name/ Doctor's Name _____
Phone Number: _____
Fax Number: _____

I hereby request that you release medical records for the following patient(s):

PLEASE PRINT FULL NAME

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

**Millennium Medical Care Reston**
**1800 Town Center Dr, #220**
**Reston, VA 20190**
**703-440-7000**
**703-440-7999**

Notes: _____

Patient or Patient's Parent/Guardian Signature: _____

Print Name: _____ Date: _____

********** *For internal purpose only* **********

First Attempt: _____
Second Attempt: _____
Third Attempt: _____