

# Capital Medical Associates, PC

## MEDICAL RECORD REQUEST

DATE: \_\_\_\_\_

DOCTOR OR PRACTICE NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

TELEPHONE AND FAX: \_\_\_\_\_

I, \_\_\_\_\_, HEREBY REQUEST THAT MY ENTIRE MEDICAL RECORD  
(PATIENT'S FULL NAME)  
BE TRANSFERRED TO THE OFFICE OF:

CAPITAL MEDICAL ASSOCIATES, PC  
1640 RHODE ISLAND AVENUE NW #800  
WASHINGTON DC 20036

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_