Thornville Family Medical Center
Request for Release of Medical Records

Records coming from:

Physician:_____
Address:_____
_____
_____
Phone #:_____ Fax #:_____

I hereby authorize that my medical records may be released to:

Thornville Family Medical Center
41 Foster Drive, P.O. Box 281
Thornville, Ohio 43076
Phone:(740)246-6361]
Fax:(740) 246-4722

Patients Name(s):_____
Address:_____
_____
_____
Phone #:_____Date of Birth:_____
Patient Signature:_____Witness Signature:_____
Today's Date:_____