TOTAL FAMILY CARE
Dr. Hylton Lightman, Medical Director

Leaving Practice - Records Request Form

Patient Information:

Patient Name:_____

Address:_____

Patient Date of Birth: _____/_____/_____ Phone Number: _____

Reason Leaving Practice:

_____

_____

How Do You Want to Receive Records (Check ONE) ***Allow 3 Business Days for Records***

PDF Sent to Patient Portal (Secure for HIPPA) _____

Pick Up TFC Office Patient or Authorized Contact _____

I hereby authorize you to release to Total Family Care of the 5 Towns and Rockaway a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Furthermore, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, is no longer protected under privacy rules.

Signature: _____ Date: _____
(Parent/Guardian if Patient is Minor/Patient if Age 18 +)

Print Name _____

TFC STAFF ONLY BELOW THIS LINE:

Notes TFC Physician/Admin/Staff Date Completed – Name Staff

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