



MULTICARE HEALTH CENTER

3840 SOUTH HARLEM AVENUE

LYONS, IL 60543

P: 708.442.3050 | F: 708.442.3058

PATIENT REQUEST FOR RECORDS

Date _____

To _____

Address _____

City _____ State _____ Zip _____

I _____ hereby authorize the release of medical records or copies of such and request that they be transferred to:

MULTICARE HEALTH CENTER

3840 SOUTH HARLEM AVENUE

LYONS, IL 60543

P: 708.442.3050 | F: 708.442.3058

Patient's Name _____

Patient's Date of Birth _____ Social Security Number _____

Patient's Signature _____