

STAR FAMILY MEDICINE
3915 Old Lee Highway
Suite 21-C
Fairfax, Virginia 22030
Tel: 703-385-6070

MEDICAL HISTORY REQUEST FORM

Date: _____

Doctor : _____

Address: _____

Dear Doctor:

I hereby authorize and request you to release the complete history records in your possession to:

Dr. _____

3915 Old Lee Highway
Suite 21-C
Fairfax, Virginia 22030

Name(s): _____

Address: _____

Signature: _____ Date: _____