

STAR FAMILY MEDICINE

3925 Old Lee Highway
Suite 52-C
Fairfax, Virginia 22030
Tel: 703-385-6070
Fax: 703-385-6073

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. _____

3925 Old Lee Highway
Suite 52-C
Fairfax, Virginia 22030

Name(s): _____

DOB: _____

Address: _____

Signature: _____ Date: _____