PRIME CARE
FAMILY PRACTICE

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ Date of Birth: _____

Physician/Entity: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

I hereby request that my medical records be released to:

Dr. Shelley Durham and Maryline Ongangi, FNP
1001 N. Waldrop Dr., Ste 801
Arlington, TX 76012
Phone: 817-962-0056
Fax: 817-962-0057
*****Secure email: patientcare@primecarefp.com*** (preferred method)**

_____ _____ _____
Signature Printed Name Date

Shelley Durham, DO
Maryline Ongangi, FNP-C

1001 N. Waldrop Dr., Ste 801
Arlington, TX 76012
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