



**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:

Maryline Ongangi, FNP

Lewis Nyantika, FNP

Dr. Eberechi Anozie

1001 N. Waldrop Dr., Ste 801

Arlington, TX 76012

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**\*\*\*Secure email: [patientcare@primecarefp.com](mailto:patientcare@primecarefp.com)\*\*\* (preferred method)**

\_\_\_\_\_  
Signature of Parent/Guardian of Minor Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient

1001 N Waldrop Dr., Suite 801  
Phone  
Arlington, TX 76012

[www.primecarefp.com](http://www.primecarefp.com)

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