



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 of Parent/Guardian of Minor Patient

Date

Printed Name

Relationship to Patient

Shelley Durham, DO

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

www.primecarefp.com

Maryline Ongangi, FNP-C

(817) 962-0056 Phone
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