MEDICAL RECORD REQUEST FORM

Requesting Clinic Information: Nectar Wellness Medical Clinic
2401 S. Washington Street, Suite G; Grand Forks, ND 58201
Phone: 1-701-739-0660 | Fax: 1-701-335-7483

Patient Information:

Full Name: ____

Date of Birth: ____ / ____ / ______

Phone Number: ____

Address: ____

City/State/Zip: ____

Records Requested (check all that apply):

☐ Most Recent Visit Notes

☐ Laboratory Results (last 12 months)

☐ Imaging Reports

☐ Medication List

☐ Other: ____

Facility / Provider Releasing Records:

Provider/Clinic Name: __________________________________

Phone: ____________________ Fax: ____________________

Address: ____

Patient Authorization:

I authorize the release of my medical records as described above.

Signature: ____

Date: ____ / ____ / ______

Please fax records to 701-335-7483 Attention: Nectar Wellness Medical