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Matthews Hematology Oncology Associates

Richard S. Foulke, M.D.
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Request for the Release of Medical Records

****Please print clearly!**

Date: _____

To: _____
(Previous physician/practice name)

Address: _____

City: _____ State: _____ Zip code: _____

Phone #: _____ Fax #: _____

I hereby request that my medical records be released to:

Matthews Hematology Oncology Associates
3036 Senna Drive
Matthews, NC 28105
Phone: 704-841-8151
Fax: 704-841-9228

Date of Birth: _____

Patient Name Printed: _____

Patient Signature: _____