

**NOLENSVILLE FAMILY MEDICINE  
JOHN R. THOMPSON, M.D.**

**940 OLDHAM DRIVE  
NOLENSVILLE, TN 37135  
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**REQUESTING OF MEDICAL INFORMATION**

Please provide us with the following information to request your records from another provider. Thank you.

Patient Name: \_\_\_\_\_  
(Please Print Clearly)

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name of Physician you are requesting medical records from :  
\_\_\_\_\_

Address Records are being requested from : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone Number where records are being requested from: \_\_\_\_\_

Fax Number where records are being requested from: \_\_\_\_\_

\_\_\_\_\_  
Signature of the Patient Date

\_\_\_\_\_  
Signature of the Guardian (Relationship to the patient) Date

\_\_\_\_\_  
Witness Date