KENNETH B. MAYBURY, M.D.
Internal Medicine
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San Francisco, CA 94117
Tel.: (415) 422-0998 Fax: (415) 422-0903

Patient Name: _____ Date: _____

To Dr. _____

Address or Fax number:

_____

_____

I, _____, request that my medical records be sent to Dr. Kenneth Maybury, at the address above. Please send the following medical records:

☐ My complete medical record.

☐ All medical records from the following date forward: _____

☐ All medical records pertaining to my diagnosis of _____

☐ Other: _____

NOTE: IF CHART EXCEEDS 40 PAGES, DO NOT FAX!
PLEASE SEND COPY BY MAIL.

_____ _____
Patient Signature / Representative Date