MEDICAL RECORDS REQUEST

RECORDS DEPT / FACILITY _____

FACILITY FAX _____

REQUESTER _____

ORGANIZATION _____

PHONE _____

FAX RECORDS TO _____

Please send the records listed below to the fax number above.

PATIENT _____

DATE OF BIRTH _____

RECORD NO. (OPTIONAL) _____

RECORDS

☐ Office notes ☐ Labs ☐ Imaging reports ☐ Discharge summary
☐ Medication list ☐ Billing ☐ Complete record

DATE RANGE _____

PURPOSE

☐ Continuing care ☐ Patient's own request ☐ Insurance ☐ Legal
☐ Other

NEEDED BY _____

ENCLOSED

☐ A signed authorization for release of information
☐ The patient's written request for access to their records

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