MEDICAL RECORDS REQUEST

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PATIENT INFORMATION

Patient Name _____ Date of birth _____

Social Security # **XXX-XX** _____ Telephone _____
(LAST FOUR NUMBERS *ONLY*)

CHECK ALL THAT APPLY:

Dates from _____ through _____

□ ALL Medical records □ Office notes □ Lab results □ Radiology reports

□ Operative/Pathology reports □ Billing records

□ Other _____

INFORMATION TO BE RELEASED **FROM:**

Name of Doctor / Hospital / Organization _____

Address _____

City _____ State _____ Zip code _____

Phone _____ Fax _____

INFORMATION TO BE RELEASED **TO:**

Name of Doctor / Hospital / Organization _____

Address _____

City _____ State _____ Zip code _____

Phone _____ Fax _____

_____ _____ _____

Date | Signature of Patient or Legally Responsible party | Relationship to patient

Authorization valid for 90 days only and may be revoked in writing at any time prior to 90 days by notifying the medical record department

(THIS FORM VALID ONLY IF SIGNED AND DATED