



## MEDICAL RECORDS REQUEST

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Dates of Service Requested: \_\_\_\_\_

Provider or Department Requested: \_\_\_\_\_

I authorize the release of the following health information:

- |  |  |
|--|--|
| <input type="checkbox"/> Consultation      | <input type="checkbox"/> History & Physical      |
| <input type="checkbox"/> ER Report         | <input type="checkbox"/> X-ray Report            |
| <input type="checkbox"/> Nurse's Note      | <input type="checkbox"/> Physician Progress Note |
| <input type="checkbox"/> Lab Report        | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Operative Report  | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Office Note       |  |

This authorization is effective immediately and will remain in effect until \_\_\_\_\_.  
I understand that all record requests require my authorization and that I may receive  
a copy of the authorization upon request. Check box if copy requested:

I understand that any applicable fees for copies of records must be paid before  
records are mailed or picked up.

\_\_\_\_\_  
Patient Signature (Or legal guardian if patient is a minor)

\_\_\_\_\_  
Date

### Please forward records to:

\_\_\_\_\_  
Physician Name / Hospital Name / Other

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

**OFFICE USE ONLY**

Completed by: \_\_\_\_\_

Date: \_\_\_\_\_