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IN OFFICE - REQUEST FOR MEDICAL RECORDS

Patient's name: _____ Date of Birth: _____

Phone Number: _____ Need Records by (date): _____

What records are needed ;

- Complete Medical Records concerning my illness and/or treatment.
- All reports of my; _____
- MRIs, X-RAYS, CTs, PETs MR Arthrograpiques of my _____
- EKG, NC.
- Hospitalizations.
- Other: _____

How would patient like to obtain records? ;

- Patient will pick up in office.
- Relative/Friend will pick up patient's records. Who? _____
- Fax records to:

- Mail records to:

I _____, have been informed of the \$25.00 fee for copy of
Print name
records and agree to this, _____ Date: _____.
Signature

*** Please give our office 7 to 10 business days to have records ready. ***

Office use only

Records Prepared by: _____ Date: _____ **Paid** **Not Paid**

Notes: _____