

# Records Request

To: \_\_\_\_\_

Attn: Records' Department

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

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

Pt Date of Birth \_\_\_\_\_ Pt SS# \_\_\_\_\_

Dates of Service/ Records Requested: \_\_\_\_\_

Notes:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Receiving Physician

Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

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

Office Phone: (    ) \_\_\_\_\_ Fax: (    ) \_\_\_\_\_

## Patient Authorization

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date