



Medical Records Request Form

Patient Name: _____

DOB: _____ Date(s) of Treatment: _____

Requested by: Patient Other _____

Information Requested:

- Anesthesia Record Billing Records Consultation Reports/Records
- Emergency Department Records History/Physical/Discharge Records Lab Results
- Nursing Notes/Records Operative Reports/Records Pharmacy Records
- Physical/Speech/Occupational Therapy Records Physician Notes/Records/Orders
- Respiratory Therapy Records Social Work Reports/Records Complete Medical Record
- Other: _____

(indicate EKG, Stress Test, Sleep Study, specific lab or radiology report, etc.)

Delivery Method:

Mail Address: _____

Fax Number: _____

Pick Up

Please note:

If a fee is due, the fee must be paid in full prior to our office sending out any medical records

Fee Due \$ _____

Date: _____ Patient Signature: _____

Witness Signature: _____

Witness Printed Name: _____