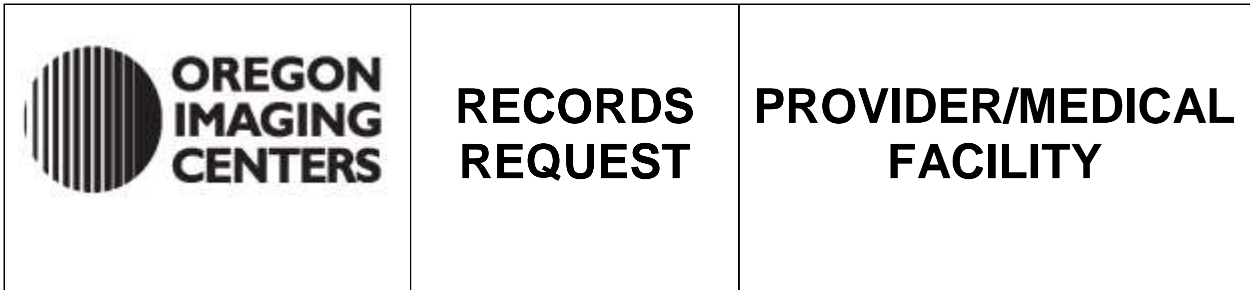

RECORDS REQUEST

PROVIDER/MEDICAL FACILITY

Patient Last Name: ______________________ Patient First Name: _________________

Date of Birth: _________________________

Who needs records?

❑ Provider? (please populate name below) ❑ Patient (for self-copy only)

If records are going to a provider, name of contact person in office?

Name: ______________________________ Phone Nbr: __________________

❑ CD ❑ Film ❑ Report ❑ Electronic

❑ Office to pick-up ❑ Patient to pick-up at ❑ UD or ❑ RBP

❑ Mail (must populate address fields below) Fax (must populate fax number below)

Street Address or PO Box: ____

City: _______________________ State: ________ Zip: ________________

Fax Number: _______________________

Images Requested: ______________________ Body Part: _______________________

Does the patient have a follow-up appointment? ❑ Y ❑ N

If yes, what is the appointment date: ________________________

Request taken by: ______________________________________

M:sm/word/