REQUEST for MEDICAL RECORDS

Date Requested

_____

Hospital / Physician / Health Care Facility Name

_____

_____

Provider Phone #

(_____)_____-_____

Provider Fax #

(_____)_____-_____

Patient Name _____

Date of Birth _____

Hosp MR # or SSN# (optional) _____

Date and Time of Patient's Appointment:

_____/_____/_____@____:_____ am/pm with_____

Please fax to us these records:

___ Labs
___ Diagnostic Results (X-Ray, MRI, Ultrasound, CT scan, CCK, ECHO, EKG)
___ ER Records (History, Physical, Consult, Discharge Summary)
___ Procedure/Surgical Results (Operative & Pathology)
___ Progress Notes
___ Other: _____

Additional Notes:

_____
_____
_____
_____

PLEASE FAX RECORDS TO
(Include this form with the records)
(703) 698-6222 or (703) 876-0722
Attn:

THANK YOU & HAVE A NICE DAY