ALL HIGHLIGHTED AREAS MUST BE COMPLETED IN ORDER TO RELEASE RECORDS

DOCTOR'S OFFICE REQUEST FOR MEDICAL RECORDS

TODAY'S DATE: _____/_____/_____
Month Day Year

PATIENT INFORMATION:

Patient Name: _____ Patient Date of Birth: _____/_____/_____
Month Day Year

DOCTOR'S OFFICE/MEDICAL CLINIC INFORMATION: Method: ❒ MAIL ❒ FAX

ATTN: _____ Address: _____

Company Name: _____ _____

_____ _____

Fax #: (_____) _____ City: _____

Phone #: (_____) _____ State: _____ ZIP: _____

PURPOSE: ❒ Continuation of Care ❒ Order Needed to Schedule Appt. ❒ Other: _____

THE ABOVE HEALTHCARE PROVIDER IS REQUESTING THE FOLLOWING MEDICAL RECORDS: (Please be specific, ex. 11/23/12 chart note or 11/23/12 MRI report.)

_____

_____

_____

THE ABOVE HEALTHCARE PROVIDER IS REQUESTING DIAGNOSTIC IMAGES TO BE MAILED ON A CD:

❒ YES ❒ NO

_____

_____

_____

THIS SECTION IS FOR REBOUND ORTHOPEDICS & NEUROSURGERY'S USE ONLY:

Medical Records	X-Ray

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