

AUTH ON FILE

- NO
- YES

- AUTHORIZED PERSON(S) _____
- EXP: _____

REQUESTED:

DATE: _____

TIME: _____

Medical records request form

In order to pick up any medical records you must present your ID and have an authorization and disclosure signed or sign one upon pick up. If you would like someone other than yourself to pick up these records you will have to sign an authorization and disclosure with the person's full legal name as it appears on their form of ID upon filling this form out. This person will need to present their ID upon picking your records up.

Note: Authorizations and disclosures are good for ONE year.

Please allow up to 14 days before your request is complete.

Last Name: _____ First Name: _____ M.I. _____

MR# _____ DOB: ____ / ____ / ____ Phone number: _____

Records requested? _____

Report **CD** Date of service: _____

Where are the records going? _____

Records needed immediately? **YES** **NO** Appt Date: _____

If yes, please state why: _____

Additional comments / Special instructions: _____

****Office use only****

Employee Name and Department

**PATIENT STICKER
(IF AVAILABLE)**