



Medical Records Request

Date of Request: _____ To: _____

Pt Name: _____ Date of Service: _____

DOB: _____ Address: _____

City: _____ City: _____

State: _____ State: _____

Requesting the following medical records:

- Physician Progress Notes (last office visit)
- Physician Notes (6 months)
- Physician Notes (Specify date) _____
- Medication list
- Labs (Within last 6 months)
- X-ray Results
- Other (Please specify) _____

Please return documents to:

- Fax to (844) 965-9687
- Email: _____
- Mail: _____
- Other: _____

Thank you!