REQUEST FOR HEALTH INFORMATION
(Complete one form for each Physician seen in the past 5 years)

REQUEST FOR RECORDS ON:

Client: **Date of Birth:**

INFORMATION REQUESTED FROM:

Dr. or Hospital: _____

Address: _____

Phone: _____

A copy or fax of this form is as valid as the original.
Thank you for your cooperation.

Signature of Patient X_____ *Date* _____

Attention Medical Records: If the package of data is large, please phone our office and we will arrange for a bonded courier to pick up the records. Otherwise records can be mailed or faxed to our offices:

Mail Address:

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