

Medical Records Request Form

Patient Name: _____

Date of Birth: _____

Date of Service: _____ (required field)

Physician's Name: _____

Date Information needed by: _____

What information is being requested? (Please check the appropriate box)

- Entire Medical Records / Chart
- History & Physical
- Consultation
- Operative Report
- Discharge Summary
- Nurse / Progress Notes
- Other specific Medical Records: _____

Please fax your request to:

Jerri Gray, Medical Records Clerk
Attn: Medical Records:
Fax: 937.331.9211

Imaging at Elizabeth Place
Fax: 888.813.0121

WARNING: UNAUTHORIZED INTERCEPTION OR USE OF THIS FAX COULD BE A VIOLATION OF FEDERAL AND STATE LAW. IF YOU HAVE RECEIVED THIS INFORMATION IN ERROR, PLEASE NOTIFY THE SENDER IMMEDIATELY. THIS FAX MAY CONTAIN CONFIDENTIAL INFORMATION BELONGING TO THE SENDER AND MAY BE USED ONLY FOR THE PURPOSE FOR WHICH IT WAS REQUESTED OR INTENDED. YOU ARE RESPONSIBLE FOR SECURING ANY CONFIDENTIAL INFORMATION.

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