RESPONSE TO REQUEST FOR MEDICAL RECORDS COVER LETTER

Department/Division/Physician
Street
City, State, Zip

To: _____ Date: _____

_____

Re: _____

SSN: _____ DOB: _____

IN RESPONSE TO THE REQUEST FOR MEDICAL INFORMATION
CONCERNING THE ABOVE-NAMED INDIVIDUAL

It is the policy of EVMS Medical Group that the last two (2) years of medical records be forwarded (unless specified otherwise). If more information is needed, please do not hesitate to contact our office.

Medical information is confidential and may be released only upon written consent of the patient. For minors or legally incompetent persons, the authorization must be signed by a parent, guardian, or legal representative, provided such signature is so labeled, and a statement is included as to why the patient cannot sign. In the case of an expired patient, the next of kin or administrator of the estate must sign the authorization.

☐ We are unable to identify this individual. If you can furnish additional information such as date of birth, dates of treatment, maiden name or alias if applicable, as well as verified spelling of the name, we will be glad to look further.

☐ It is the policy of EVMS Medical Group that all authorizations must be signed and dated by the patient within ninety (90) days of presentation to EVMS Medical Group. As soon as we have received the completed authorization, we will forward the requested information.

☐ The enclosed record is incomplete. Please contact the patient for details.

_____
(Signature)

_____
(Phone Number)