Medical Records Request Form

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By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or a summary of my protected health information to the physician or facility requesting these records.

Doctor/Hospital Name:_____

Address:_____

Fax Number:_____

Patients Name: _____ **Patient's DOB:** _____

Patient's Signature: _____

Dr. Ogletree is requesting the following medical records;

__ **Facesheet/ Demographics**

__ **Clinicals/Progress Notes/office visit summary**

__ **Operative Report**

__ **Imaging Test Results**

__ **Lab Results**

Comments:

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