Patient Request for Medical Records

Doctor/Clinic Name: ____________________
Address: ____________________
____

Patient Name: ____________________
Address: ____________________
____
DOB: ____________________
ID #: ____________________
Parent/Guardian: ____________________

Please mail a complete copy of my medical records, including any chart notes, laboratory/diagnostic test results, and procedures performed to the address listed below, for the following dates of care:

From: ____________________ To: ____________________

Mail Records To: ____________________

Address: ____________________

____

Purpose: ____________________

Thank you for your assistance with this request.

Patient/Parent Signature: ____________________

Date Records Requested: ____________________

Medications/Supplements History

Medication Name: Date Started: Dosage: Effectiveness (1-min/5-max):

Side Effects Noted:

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Side Effects Noted:

Patient Update

Current Medications/Vitamins

Drug/Supplement Name	Dosage	How Often	Refill Needed Y/N
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Pharmacy Name: ______________________ Phone: ______________

Current Symptoms/Complaints

Problem/Concern	How Often	Severity (1-mild/10-severe)
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Specialists Consulted/Diagnostic Tests Since Previous Visit

Date	Facility	Reason	Action
1.			
2.			

Requests for Action on Behalf of the Patient – Referrals, Education, Resources, etc.

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Patient Signature: ______________________ Date: ______________

Family Medical History

Patient Name: ______________________ Date Updated: __________

Illness: Age if Deceased: Patient Relation:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Allergies/Asthma: Reaction: Patient Relation:

1.
2.
3.

Mental Health Impairments: Patient Relation:

1.
2.

Developmental/Learning Impairments: Patient Relation:

1.
2.

Genetic Markers/Predispositions: Patient Relation:

1.
2.

Toxin Exposed To: Date of Exposure: Patient Relation:

1.
2.

Family History of Substance Abuse (Y/N): Which:

Family History of Eating Disorders (Y/N): Which:

Communication Log - Care/Insurance Providers

PROVIDER: ______________________ **DATE:** ____________
REPRESENTATIVE: ______________________

ISSUES DISCUSSED: ______________________

RESOLUTION/STEPS TO BE TAKEN: ______________________

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RESOLUTION/STEPS TO BE TAKEN: ______________________