DIGESTIVE HEALTHCARE OF GEORGIA, P.C.

MEDICAL RECORDS REQUEST

Date_____/_____/_____

TO:_____

Phone: (_____)-_____-_____ **Fax: (_____)-_____-_____**

FROM:_____

***** In accordance to HIPAA Privacy Rule {45 CFR 164.506} General Provisions, a "Covered Entity" may without the individuals authorization, send a copy of an individual's medical record to a specialist who needs the information to treat the individual*****

****PLEASE FORWARD ONLY THE RECORDS SPECIFIED BELOW****

Patient:_____**MRN:**_____

DOB:_____/_____/_____ **Last 4 of SS#**_____

Patient has an appointment with our office on:_____/_____/_____

Date of Service Requested (if available):_____/_____/_____

__ **Admission/Discharge Summary**

__ **Demographics & Insurance Cards/Info**

__ **History & Physical**

__ **Lab Reports** __**Most Recent**__ **Last 2 Reports**

__ **Medication List**
(Specify)_____

__ **Office Visit Notes (Last 2)**

__ **Operative Procedure Report**

__ **Pathology Reports**

__ **Radiology Results** __ **Abdomen**___**Pelvis**

__ **Chest** __**Other**

__**No Records Found on this Patient**

Notes:_____

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