

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

Office Visit Notes (Last 2)

Demographics & Insurance Cards/Info

Operative Procedure Report

History & Physical

Pathology Reports

Lab Reports Most Recent Last 2 Reports

Radiology Results Abdomen Pelvis

Medication List
(Specify) _____

Chest Other

No Records Found on this Patient

Notes: _____

Confidentiality Notice: The information contained in or with this fax transmission is legally privileged and confidential information intended only for the use of the individual/entity named as recipient above. If you are not the intended recipient of this message you are hereby notified that any dissemination, distribution, or copying of this transmission is strictly prohibited. If you received this transmission in error, please notify the sender immediately via telephone and return all the information included in this transmission to the address listed above via U.S. Mail.