

2340 Hampton Ave.

Saint Louis, MO 63139

P. (314) 647-2200

F. (314) 647-4172

Patient Request for Health Record

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Last 4 of patient SS# \_\_\_\_\_\_\_\_\_

**Time Period**

□ ALL RECORDS or □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Record Type**

□ ALL Records or □ Specific

□ Labs □ Progress Notes □ Diagnostics

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How would you like records sent to you?**

□ Email as pdf to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(email)

□ Pick up CD from office

□ Mail them to me at this address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Signature Date of Request