Request of medical records

Format:

Printed ◯ Electronic ◯ _____.

# of copies_____.

Patient information

Patient's full name:

_____ __.
Patient's ID _____.
Date of service: _____.
Discharge date: _____.
Phone number:_____.

Hospitalization ( ) Ambulatory Surgery ( ) Emergency ( )

I authorize a third party to pick up the information

◯ Yes, Full name and ID_____.
◯ No.

Signature _____.

Remember:
Bring your ID to retrieve your copy
Ask for the cost of the copy, in case it was not provided previously.