Stanford HEALTH CARE
STANFORD MEDICINE

Request for Specific External Medical Records

(This form is for University Healthcare Alliance (UHA). Continuing Care use only when requesting records from outside providers.)

DATE: ____________________

TO: ______________________________ Name of Healthcare Provider or Facility
______________________________Address
____
Phone____________________ Fax ______________________

FROM:

Alliance Medical Group
100A San Pablo Towne Center
San Pablo, CA 94806
Phone: 510-237-2802

The following patient, currently being seen in our office, has indicated that he/she has records in your office. These records are required for us to provide continued care to our patient. Your timely response to this request is very much appreciated.

Patient: ______________________________ DOB: ____________

Records for the following dates are needed (List specific dates, if known):

____

Please fax the following items:

Last ___ Office Visit Notes
Last 1 Year of Lab Results
Immunizations
Growth Charts
Last Mammogram Report
Last Pap/HPV Result
Last Bone Density Test
Last EKG/Echocardiogram/ Stress Test
Last Diabetic Eye Exam
Last Endoscopy/EGD/ Colonoscopy/Sigmoidoscopy And related Pathology Reports

Other Radiology Report: ____
Other: ____
Other: ____

Records should be faxed to: 866-601-1562 510-237-0669

Thank you,

______________________________ ______________________________
(Patient Signature) (date)

This request is fully compliant with the Treatment, Payment, and Health Care Operations (TPO) disclosure requirements as defined in the HIPAA Privacy Rule 45 CFR 164.501