Stanford HEALTH CARE
STANFORD MEDICINE

Please Place Patient Label Here

Request for Medical Records

DATE: _____

To: _____

Address: _____

_____

Phone: _____

Fax: _____

From: Stanford Primary Care- Los Altos

Healthcare Provider: _____

PCC (Point of Contact): _____

Phone: (650) 498-9000 **Fax:** (650) 736-6353

Address: 960 N. San Antonio Rd, Suite 101

Los Altos, CA 94022

The following patient is currently receiving care at Stanford Primary Care and has indicated that he/she had records in your office. These records are required for us to provide continuing care to our patients. Your timely request is very much appreciated.

Patient: _____

DOB: _____

Records for the following dates are needed (List specific dates or note "all"): _____

Please send:

☐ Last ___ Office Notes
☐ Lab Results Within Last Year
☐ Immunizations
☐ Growth Charts
☐ Last Mammogram Report
☐ Last PAP / HPV report
☐ Last Bone Density Test
☐ Last EKG / Echo / Stress Test
☐ Last Diabetic Eye Exam
☐ Last Endoscopy / EGD/ Colonoscopy / Sigmoidoscopy / Fecal Test
☐ Other Radiology Report: _____
☐ Other: _____
☐ Full chart

Records should be Faxed / Mailed (please circle one) to the address or fax above.

If radiology images requested, please overnight mail to the above address, care of the physician noted above.
Thank you,

_____ _____

Requester's 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