RECORDS REQUEST

TOTAL CARE CLINICS
Jeff Grawe, ARNP / Aaron Johnson, ARNP

Request Date: _____

PATIENT INFORMATION

Patient Name:

Address:

City: **State:** **Zip:**

Phone #:

Date of Birth:

RELEASE INFORMATION FROM...

Organization:

Address:

City: **State:** **Zip:**

Phone #:

Fax #:

INFORMATION TO BE RELEASED

(Please check ALL that apply)

SERVICE DATES FROM _____ TO _____

☐ ER Records / Notes	☐ Billing Information	☐ Clinic Records / Notes
☐ Radiology / Imaging X-ray Reports	☐ Notes or Reports from Other Providers	☐ Lab Reports

ADDITIONAL INFORMATION

RELEASE INFORMATION TO...

Organization:

Address:

City: **State:** **Zip:**

Phone #:

Fax #:

AUTHORIZED BY:

Print Name:

Date:

Signature:

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