

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:

|  |  |  |
| --- | --- | --- |
|  | **Alameda Pediatric Associates** |  |
|  | 1332 Park St. Suite 202 |  |
|  | Alameda, CA 94501 |  |
|  | Phone: 510-523-3417 Fax: 650-498-8737 |  |

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 Growth Charts  Last Pap/HPV Result

 Last 1 Year of Lab Results  Newborn Screening Result  Chlamydia Test

 Immunizations

 Other:

**Records should be faxed to:  650-498-8737**

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**