**<Facility logo placement>**

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| **Medical Records Request Form****Date of Request: \_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient’s Date of Birth (DOB)**: \_\_\_\_\_\_\_\_\_\_\_\_   Checking this box indicates that the dialysis facility listed at the bottom of this form has obtained patient consent to request medical records **(for the dialysis facility only).** |
| **Requested Records** Hospital Discharge Summary **Admissions Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Discharge Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date(s) of service for the record(s) indicated below** (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Department (ED) Discharge Summary (including lab results, procedures performed)  Blood cultures/microbiology report/laboratory results  Cause of Death Reason (for CMS Form 2746)  History and physical  In-patient specialist consultation (e.g. cardiology, psychiatry, etc.)  Operative reports  Outpatient diagnostic/interventional procedures/reports (e.g. interventional radiology)  Out-patient specialist consultation for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

Please send the selected medical records via secure fax or secure, encrypted email to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, **within 24 hours** of receipt for this request to ensure proper continuation of medical treatment.

Requested by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Dialysis Facility Contact Person)

Dialysis Facility Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dialysis Facility Medical Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name) (Signature)