West Gastroenterology Medical Group

Request Received: Date: ____________________ Time: ____________ MR# ____________________

FAX REQUEST for MEDICAL RECORDS

To:

West Gastroenterology Medical Group (West GI)
P.O. Box 881840
Los Angeles, CA 90009
Phone: (310) 674-0144
Fax: (310) 674-1704

Patient's Full Name:
Date of Birth: _______/_______/_____________
Social Security No: ________-________-___________
West GI Medical Record Number: ____________________

From:

Your Name: ____

Date/Time of Request: ____/____/______ **am/pm**

Health Care Provider: ________________________________

☐ **West GI Medical Staff Member**

☐ - Check here if Provider is **NOT** a covered entity under the HIPPA Privacy Rule. In this case, patient authorization may be required.

Phone Number: (__________)_____________________________

When Information is Needed:

☐ Patient Care Emergency ! Need **STAT**!
☐ Urgent — Patient or doctor is present and waiting
☐ As Soon as Possible
☐ By A Specific Date: _______/ _______/ ____________________

(This information is gathered to prioritize requests and attempt to meet customer needs. It does not guarantee that CRMC can meet all requested time frames)

Please Describe the Information to be Release (Mark All That Apply):

☐ Pathology Reports
☐ Facesheet
☐ Discharge Summary
☐ History & Physical
☐ Consultation
☐ Procedure Reports
☐ Copy of Insurance Card
☐ Abstract of Key Reports
☐ Laboratory Reports
☐ X-Ray/Imaging Reports
☐ Complete Chart
☐ Imaging
☐ Films/Studies
☐ Progress Notes by Doctor
☐ Other: ____________________________

For the Following Date(s) of Service: ____

Please Send Information Via:

☐ Mail **Address:** ____

☐ Fax **Fax Number:** (__________)_____________________________
(Ensure that fax machine is accessible only by authorized individuals.)

Purpose of Disclosure

☐ Treatment ("Minimum necessary" does not apply)
☐ Payment or Billing Purposes
☐ Operations - for health care operations activities of the entity that receive information. If each entity has or had a relationship with the individual who is the subject of the protected health information being requests the protected health information pertains to such relationship.

☐ Other: ____