# Medical Records Request Form

**Attention:** _____

**Submitted on:** _____

**Requested by:** _____**Phone:** _____**Fax:** _____
*(Dialysis Facility Contact Person)*

**Dialysis Facility Name and Address:** _____
_____

Please fax the requested medical records to: _____ **within 24 hours** of receipt of this request to ensure appropriate continuation of medical treatment.

**Medical Records Requested for:** _____
*(Patient Name)*

**DOB:** _____ **Admission Date:** _____

☐ **All Records Listed Below**

- ☐ Blood Cultures/Microbiology Report
- ☐ Death Summary (if applicable)
- ☐ Diagnostic Procedures (e.g. vein mapping, interventional radiology)
- ☐ Discharge Medications
- ☐ History & Physical
- ☐ Hospital Discharge Summary
- ☐ Laboratory Results
- ☐ Invasive Procedures/Operative Reports (including central venous catheter or vascular access placement)

☐ Other: _____

Dialysis Facility Medical Director: _____
*(Name)*

_____
*(Signature)*

**Internal Use Only**

Date Records Received: _____

**Health Insurance Portability and Accountability Act (HIPAA) Disclosure: The HIPAA Privacy Rule permits health care providers to share protected health information for treatment purposes without patient authorization, as long as they use reasonable safeguards when doing so. These treatment communications may occur orally or in writing, by phone, fax, email or otherwise.**

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