Stanford HEALTH CARE

Request for Specific 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:

North Oakland Family Practice
3100 Telegraph Ave., Suite 2102
Oakland, Ca. 94609
Phone: (510) 286-8160 Fax: (510) 286-8158

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	Last Mammogram Report	Last Diabetic Eye Exam
Last 1 Year of Lab Results	Last Pap/HPV Result	Last Endoscopy/EGD/
Immunizations	Last Bone Density Test	Colonoscopy/Sigmoidoscopy
Growth Charts	Last EKG/Echocardiogram/ Stress Test	And related Pathology Reports

Other Radiology Report: _____
Other: _____
Other: _____

Records should be faxed to: (510) 286-8158

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