SONIC HEALTHCARE USA
Anatomic Pathology

# PATIENT RECORD REQUEST FORM

FORM MUST BE SUBMITTED ALONG WITH FRONT AND BACK COPY OF DRIVERS LICENSE

## 1: PATIENT INFORMATION:

*Name -Last *First MI

Other names to search (maiden name, nickname, former names, etc)

Address City State ZIP

Cell Phone or Other Primary Phone

*Date of Birth M M - D D - Y Y Y Y

*Sex

## 2. PLEASE INDICATE THE MEDICAL RECORDS REQUESTED:

| Ordering Physician Name | Ordering Physician City & State | Date of Service Month & Year |
|---|---|---|
| | | |
| | | |
| | | |

❑ Other records, specify records requested and approximate date of service

## 3. PLEASE SELECT ONE OF THE FOLLOWING METHODS FOR TRANSMISSION:

Send to (enter Name if different from above):

*By (please mark one):

❑ Email address:
❑ Fax Number:
❑ Mail *(enter address if different from above)*:

My signature below authorizes Sonic Healthcare USA Anatomic Pathology to release the records containing Protected Healthcare Information (PHI) I have requested:

**4. *Signature** ***Date**

*Relationship: ❑ Self ❑ Parent (provide proof) ❑ Legal Gaurdian (provide proof) ❑ Personal Representative (provide proof)

*Printed Name: *Initials:

## PLEASE SUBMIT COMPLETED FORM AND FRONT AND BACK COPY OF DRIVERS LICENSE:

**Twin Cities Dermatopathology**
9900 13th Ave N, Suite 2A
Plymouth, MN 55441

Phone: 763.525.0363
Fax: 763.525.0369
Email: tcdinfo@sonichealthcareusa.com

Patient Verification of Information

Initials _____
Date _____

For patient safety, any changes to information require a new form to be completed.
*Indicates REQUIRED Information