Robert E. Scott, Jr., M.D.

Spine Care • Musculoskeletal & Sports Injuries • Neurodiagnostic Testing • Pain Management

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REQUEST FOR RELEASE OF MEDICAL RECORDS

\*\*There is a ***minimum*** $15.00 copy fee\*\*

I hereby request Dr. Robert Scott to provide copies of the medical record for:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Workers Comp Private 



Approximate dates of first and last treatment/visit:

\* Appropriate documentation is required prior to the release of medical records

Patient











Parent of minor

Guardian of minor\*

Conservator of the patient\* Beneficiary/ personal representative of deceased patient\*

Attorney-in fact under durable power of attorney for health care law\*

Send me copies of the record as indicated below:

All medical information (chart notes)

□

✔

Imaging studies only

□

□

Lab results only

 Billing Records

Dates of service requested: From to

I hereby authorize Dr. Robert Scott to furnish the above noted information to:

Mail to patient address Mail to address below Fax to number below

□

□

□

Name:

Complete Address:

Phone Number (including area code):

Fax Number (including area code):

Signature: Date:

\*Note: if not the patient, appropriate documentation is required, please see above.