Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Request for Medical Records**

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

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_) \_\_\_-\_\_\_\_

Phone: (\_\_\_) \_\_\_-\_\_\_\_

I am requesting that you provide copies of my medical records, as specified:

\_\_All medical records or chart notes

\_\_Records generated in the past 12 months

\_\_Records pertaining to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of the request is: \_\_ Consultation \_\_ Establish Care \_\_ Specialty Treatment

Please send the records to:

**Copper Valley Medical**

**Attn: Dr. Don Selvey, NMD**

**4955 S. Alma School Road, 10**

**Chandler, Arizona 85248**

**(602) 680-1025 - fax**

**Secure Email:** [**Info@coppervalleymedical.com**](mailto:Info@coppervalleymedical.com)

The records are requested as soon as possible; the patient is awaiting treatment.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

**Thank you for your prompt response to this request.**

**If you have questions, please call us at (602) 566-2015**