



## Request for Specific External 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:

**Alameda Pediatric Associates**

1332 Park St. Ste. 202

Alameda, CA 94501

Phone: 510-523-3417      Fax: 510-521-1659

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:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Last ___ Office Visit Notes | <input type="checkbox"/> Last Mammogram Report                   | <input type="checkbox"/> Last Diabetic Eye Exam    |
| <input type="checkbox"/> Last 1 Year of Lab Results  | <input type="checkbox"/> Last Pap/HPV Result                     | <input type="checkbox"/> Last Endoscopy/EGD/       |
| <input type="checkbox"/> Immunizations               | <input type="checkbox"/> Last Bone Density Test                  | <input type="checkbox"/> Colonoscopy/Sigmoidoscopy |
| <input type="checkbox"/> Growth Charts               | <input type="checkbox"/> Last EKG/Echocardiogram/<br>Stress Test | And related Pathology Reports                      |

Other Radiology Report: \_\_\_\_\_

Other: \_\_\_\_\_

Other: \_\_\_\_\_

**Records should be faxed to:**     **916-239-3614**     **510-521-1659**

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**