Stanford HEALTH CARE

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:

- ☐ Last ___ Office Visit Notes
- ☐ Last 1 Year of Lab Results
- ☐ Immunizations
- ☐ Growth Charts
- ☐ Last Mammogram Report
- ☐ Last Pap/HPV Result
- ☐ Last Bone Density Test
- ☐ Last EKG/Echocardiogram/ Stress Test
- ☐ Last Diabetic Eye Exam
- ☐ Last Endoscopy/EGD/ Colonoscopy/Sigmoidoscopy 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