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:

Munir Javed, MD
2204 Grant Road
Suite 203
Mountain View, CA 94040
Phone: 650-940-1335

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 Mammogram Report	Last Diabetic Eye Exam
Last 1 Year of Lab Results	Last Pap/HPV Result	Last Endoscopy/EGD/
Immunizations	Last Bone Density Test	Colonoscopy/Sigmoidoscopy
Growth Charts	Last EKG/Echocardiogram/ Stress Test	And related Pathology Reports

Other Radiology Report: _____

Other: _____

Other: _____

Records should be faxed to: 650- 968-2723

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

Last revised March 2015