



## 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:

**Kwok Pediatrics and Internal Medicine**

825 Pollard Road

Suite 108

Los Gatos, CA 95032

Phone: 408-370-3774

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/<br>Stress Test | And related Pathology Reports |

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

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

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

**Records should be faxed to: 408-370-7011**

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**