Pediatric care FOUR CORNERS

Medical Records Request Form

Eiman ElSayed, M.D.

Patient Name: _____

Date of Birth: _____ Sex: M or F Social Security # ___-____- ____

Address: _____

Parent/Guardian: _____ Relationship:_____

Date of Request: _____ By: _____

Purpose of Request: _____ (Continued care, personal, etc.)

Type of Records Requested

☐ New patient establishing care: Entire chart, including growth chart, vaccine records, most recent well child exam, summery of medical issues, labs, radiology reports, etc.

☐ Hospital records: Newborn/Emergency Department/Hospital Admission

☐ Other: _____

Dates of Service: _____

Office/Facility Information

Office/Facility Name:_____

Provider: _____ Department: _____

Phone: _____ Fax: _____

Address: _____

I, _____hereby authorize _____, to release any and all information which they possess relating to my child's examinations and illness during hospitalization, emergency room treatment, and/or outpatient visits relating to the dates mentioned above. This is to include all reports, if any, concerning HIV testing, psychiatric and/or psychological information and drug and/or alcohol abuse. The question of privacy between your institution, my attending physician and me is waived. This authority extends to the furnishing of copies of all or any desire parts of the records of your institution and is good for one year from the date below. I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

_____ _____

Signature of Patient, Parent, or Guardian **Please Print Name**

_____ _____

Date Signed **Witness**