The Medical Center at Elizabeth Place

Medical Records Request Form

Patient Name: _____

Date of Birth: _____

Date of Service: _____ (required field)

Physician's Name: _____

Date Information needed by: _____

What information is being requested? (Please check the appropriate box)

- ☐ Entire Medical Records / Chart
- ☐ History & Physical
- ☐ Consultation
- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Nurse / Progress Notes
- ☐ Other specific Medical Records: _____

Please fax your request to:

Jerri Gray, Medical Records Clerk
Attn: Medical Records:
Fax: 937.331.9211

Imaging at Elizabeth Place
Fax: 888.813.0121