

# Patient File Request Form

Please fill out the following. Please print legibly:

1. Date of Request \_\_\_\_\_

2. Name of Requestor \_\_\_\_\_

Patient Name at Date of Service \_\_\_\_\_

(NOTE: If this name is different than the Requestor, proper documentation must be included)

Address \_\_\_\_\_

Phone No. (\_\_\_\_\_) \_\_\_\_\_ Fax No.(\_\_\_\_\_) \_\_\_\_\_

E mail: \_\_\_\_\_

3. Date of Birth: \_\_\_\_\_

4. Date of Service: \_\_\_\_\_

NOTE: Your file will be mailed to the above address

I certify that I (name), \_\_\_\_\_, am the patient who received services on the above date at the following clinic:

Clinic Name \_\_\_\_\_

Clinic Address \_\_\_\_\_

Requestor signature \_\_\_\_\_ Date \_\_\_\_\_

THE ABOVE SIGNEE IS SWORN TO BE THE PERSON SHE PURPORTS TO BE on this date: \_\_\_\_\_

Notary Public: \_\_\_\_\_ My Appointment Expires: \_\_\_\_\_

Please include a copy of a Government-issued photo identification with your request.

Please include a copy of your paid receipt for services if you have it.

The cost of retrieving the file is a \$10 retrieval fee which must be sent in the form of a cashier's check or money order made out to CASH.

Please mail all of the above information to PO Box 18969, Raleigh NC 27619

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*For Retrieval Use Only:*

Person processing request \_\_\_\_\_ Date \_\_\_\_\_