SONIC HEALTHCARE USA
Anatomic Pathology

PATIENT RECORD REQUEST FORM

FORM MUST BE SUBMITTED ALONG WITH FRONT AND BACK COPY OF DRIVERS LICENSE

1: PATIENT INFORMATION:

*Name -Last *First MI

Other names to search (maiden name, nickname, former names, etc)

Address City State ZIP

Cell Phone or Other Primary Phone

*Date of Birth M M - D D - Y Y Y Y

*Sex

2. PLEASE INDICATE THE MEDICAL RECORDS REQUESTED:

Ordering Physician Name	Ordering Physician City & State	Date of Service Month & Year

❑ Other records, specify records requested and approximate date of service

3. PLEASE SELECT ONE OF THE FOLLOWING METHODS FOR TRANSMISSION:

Send to (enter Name if different from above):

*By (please mark one):

❑ Email address:
❑ Fax Number:
❑ Mail *(enter address if different from above)*:

My signature below authorizes Sonic Healthcare USA Anatomic Pathology to release the records containing Protected Healthcare Information (PHI) I have requested:

4. *Signature ***Date**

*Relationship: ❑ Self ❑ Parent (provide proof) ❑ Legal Gaurdian (provide proof) ❑ Personal Representative (provide proof)

*Printed Name: *Initials:

PLEASE SUBMIT COMPLETED FORM AND FRONT AND BACK COPY OF DRIVERS LICENSE:

Fax: 833.706.2437

Email: patientbilling@propath.com

For assistance, please call 800.654.1888 or 214.631.1621

For patient safety, any changes to information require a new form to be completed.
*Indicates REQUIRED Information

Patient Verification of Information

Initials _____
Date _____

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