



A Division of Northwest Surgical Specialists, P.C.
200 NE Mother Joseph Place, Suite 210
Vancouver, WA 98664
Phone: 360.449.1141 Fax: 360.449.1146 www.reboundmd.com

ALL HIGHLIGHTED AREAS MUST BE COMPLETED IN ORDER TO RELEASE RECORDS.

DOCTOR'S OFFICE REQUEST FOR MEDICAL RECORDS

TODAY'S DATE: ____/____/____
month day year

PATIENT INFORMATION:

Patient Name: _____ **Patient date of birth:** ____/____/____
month day year

DOCTOR'S OFFICE / MEDICAL CLINIC INFORMATION:

Method: ☐ MAIL ☐ FAX

ATTN: _____ **Address:** _____
Company Name: _____

Fax #: (____) _____ **City:** _____
Phone #: (____) _____ **State:** _____ **ZIP:** _____

PURPOSE: ☐ Continuation of Care ☐ Order Needed to Schedule Appt. ☐ Other: _____

THE ABOVE HEALTHCARE PROVIDER IS REQUESTING THE FOLLOWING MEDICAL RECORDS: (Please be specific) Ex. 11/23/12 chart note or 11/23/12 MRI report

THE ABOVE HEALTHCARE PROVIDER IS REQUESTING DIAGNOSTIC IMAGES TO BE MAILED ON A CD:

☐ YES ☐ NO

THIS SECTION FOR REBOUND USE ONLY:

*Medical
Records*

X-Ray