

LAKESIDE ORTHOPEDIC CLINIC

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FAX TRANSMISSION — 02/11/2026 10:44 AM — Pages: 1
TO: Whispering Pines Family Medicine / Medical Records Dept
FAX: (555) 867-5309
FROM: Lakeside Orthopedic Clinic — Dr. Marcus Bellingham, MD

REQUEST FOR MEDICAL RECORDS

Pursuant to signed patient authorization (HIPAA compliant)

PATIENT INFORMATION:

Patient Name: DELACROIX, THOMAS R.
Date of Birth: 09/22/1971
SSN Last 4: XXXX (on file with authorization form)
Phone: (555) 998-3321

- ☐ Immunization Records
- ☐ Surgical/Procedure Notes
- ☒ Referral Correspondence
- ☐ Complete Medical Record

RECORDS REQUESTED:

Date Range: January 2024 — Present
Record Types:
☒ Office/Progress Notes
☒ Lab Results
☒ Imaging Reports
☒ Medication List

REASON FOR REQUEST:

New patient evaluation for chronic low back pain. Patient is transferring orthopedic care. Need to review prior treatment history and imaging to avoid unnecessary duplicate testing.

AUTHORIZATION:

Signed patient authorization form is on file at our office.
A copy will be mailed upon request or can be faxed to (555) 867-5309.

Please fax records to: (555) 776-4401 ATTN: Medical Records / Dr. Bellingham
If questions, please call (555) 776-4400 and ask for Rebecca (Records Coordinator).

This request is made in compliance with HIPAA Privacy Rule (45 CFR 164.524). Records should be provided within 30 days.