EISENMAN & EISENMAN, MD, LLC

Diplomat American Board of Gastroenterology
5065 SR 7 SUITE 201
LAKE WORTH, FL 33449
PHONE: 561-753-7487 FAX: 561-753-8161

DATE:_____ Doctor:_____

MEDICAL RECORDS REQUEST

TO: _____ **FAX #:** _____

RE: Patient: _____ **DOB:** _____ **LAST 4# SS:** _____

This office is seeing the above patient and we are requesting a copy of the following Medical Information in order to provide the best care for this patient. Thank you.

_____ **Recent Lab/Blood Work**
_____ **CT Scan Results**
_____ **MRI Results**
_____ **PET Scan Results**
_____ **Ultrasound Results**
_____ **Office Notes**
_____ **Surgical Note with Pathology (if applicable)**
_____ **Colonoscopy / Upper Endoscopy Report with Pathology**
_____ **Recent EKG**
_____ **Medication List**
_____ **Other:** _____

Medical Release Authority: I, _____, (Patient or Guardian) hereby request that you release the above information request, as well as any other pertinent data regarding my treatment: From: _____ to _____ OR ALL. Please release to the practice of Eisenman & Eisenman, MD, LLC – in whole or in part.
FAX: 561-753-8161:MAILING ADDRESS: 5065 SR 7 SUITE 201, LAKE WORTH, FL 33449.

Patient Signature: _____ **Date of Request:** _____

Witness: _____ **Date:** _____

V 8/14tb