LifeBack
Get Yours.

4 Princess Road • Lawrenceville, NJ 08648
Phone: (609) 482-3701 • Fax: (609) 482-3702

Medical Records Request Form

Patient Name: _____ DOB: _____ Date: _____

What type of records are being requested? (for example, Notes, Assessments, Test Results)

_____

_____

Date range requested (Month/Year and Specific Dates) From_____ To _____.

Recipient/Agency Name: _____

Address:_____

_____

Phone Number: _____ Fax Number:_____

Email Address: _____@_____.com

Reason: _____

**Please allow at least 7 business days for medical record requests.*
All requests require approval prior to being released.

Patient Signature: _____ Date: _____

Front office use only

Does Patient have a Current Medical Records Release on file? _____

_____ Approving Physician: _____
initial *print name*

_____Approving Therapist: _____
initial *print name*

_____ _____ _____
Name of person completing request: *Completion Date*: *Initial:*

Comments _____