Robert E. Scott, Jr., M.D.

Spine Care • Musculoskeletal & Sports Injuries • Neurodiagnostic Testing • Pain Management

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REQUEST FOR COPIES OF MEDICAL RECORDS

There is a ***minimum* $15.00 copy fee**

I hereby request Dr. Robert Scott to provide copies of the medical record for:

Patient Name: _____

Date of Birth: _____

Workers Comp ☑ Private ☐

Approximate date of last treatment/visit: _____

I request this as:

* Appropriate documentation is required prior to the release of medical records

☑ Patient ☐ Parent of minor ☐ Guardian of minor*
☐ Conservator of the patient* ☐ Beneficiary/ personal representative of deceased patient*
☐ Attorney-in fact under durable power of attorney for health care law*

Type of request

Copies of the record as indicated below:

☑ All medical information without exception (this includes substance abuse documentation and any result of blood tests/all reference to those results
☐ Billing information
☐ X-ray report
☐ MRI report

Dates of service requested: From _____ to present

I hereby authorize Dr. Robert Scott to furnish the above noted information to:

☐ Mail to patient address ☐ Mail to address below ☐ Fax to number below

Name: _____

Complete Address: _____

Phone Number (including area code): _____

Fax Number (including area code): _____

Signature: _____ Date: _____

Note: if not the patient, appropriate documentation is required, please see above.