SONIC HEALTHCARE USA
Anatomic Pathology

PATIENT RECORD REQUEST FORM

FORM MUST BE SUBMITTED ALONG WITH FRONT AND BACK COPY OF DRIVERS LICENSE

1: PATIENT INFORMATION:

*Name -Last *First MI

Other names to search (maiden name, nickname, former names, etc)

Address City State ZIP

Cell Phone or Other Primary Phone *Date of Birth __ __ - __ __ - __ __ __ __ *Sex

2. PLEASE INDICATE THE MEDICAL RECORDS REQUESTED:

Ordering Physician Name	Ordering Physician City & State	Date of Service Month & Year

❑ Other records, specify records requested and approximate date of service

3. PLEASE SELECT ONE OF THE FOLLOWING METHODS FOR TRANSMISSION:

Send to (enter Name if different from above):

*By (please mark one):

❑ Email address:
❑ Fax Number:
❑ Mail *(enter address if different from above)*:

My signature below authorizes Sonic Healthcare USA Anatomic Pathology to release the records containing Protected Healthcare Information (PHI) I have requested:

4. *Signature ***Date**

*Relationship: ❑ Self ❑ Parent (provide proof) ❑ Legal Gaurdian (provide proof) ❑ Personal Representative (provide proof)

*Printed Name: *Initials:

PLEASE SUBMIT COMPLETED FORM:

Address:
Western Pathology Consultants
343 Elm St. #206
Reno NV 89503

Phone: 775.746.3400 option 1
Fax: 775.746.3411
Email: WPCTranscription@sonichealthcareusa.com

Patient Verification of Information
Initials _____
Date _____

For patient safety, any changes to information require a new form to be completed.
*Indicates REQUIRED Information