…a division of BASS Medical Group

Request to Obtain Medical Records

Please complete this form in its entirety and we will promptly forward your request. This authorization is necessary for us to comply with state and federal laws pertaining to the request and/or release of medical records regarding the patient identified below. Failure to provide all requested information may prevent Blackhawk Medical Group from acting on this request.

Patient Name ____ Date of Request ____/____/____

Date of Birth _____/_____/_____

Person Authorized to Request Medical Records

(Patient, Parent or Guardian)

Name ______________________________

Address ______________________________

City, State ______________________________

ZIP ______________________________

Phone: ______________________________

Please send this authorization to:

Dr/Hospital: ______________________________

Address ______________________________

City, State ______________________________

ZIP ______________________________

Phone: ______________________________

FAX: ______________________________

Please Send My Medical Records To:

Blackhawk Medical Group

4165 Blackhawk Plaza Circle Suite 100

Danville, CA 94506

Phone: 925-736-7070 **FAX: 925-736-7075**

Information to be sent: Please check accordingly.

_____ All Medical Records

_____ Only those checked below during the date range specified here: ________________________

_____ Billing Records _____ EKG/TMT Results _____ Medications

_____ X – Ray Results _____ History & Physical _____ Lab/Pathology

_____ Progress Notes _____ Immunizations _____ Reports

_____ Other ____

____ **Date ____/____/____**

Patient or Authorized Signature