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? (Notes, Assessments, Test Results, etc…)

_____

_____

Date range requested (Month/Year, Specific dates...)

From_____ to _____.

Recipient: _____ Phone Number: _____

Fax Number: _____ Reason: _____

*Please allow at least one week for medical record requests. All requests require approval before they can be released.

**Front Office Use Only:** Is there an active release signed? _____

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Approval

Psychiatrist: _____ Signature: _____ Date: _____

Therapist: _____ Signature: _____ Date: _____

Completion

Date sent: _____ Initial: _____

Comments

_____

_____