REQUEST FOR PATIENT HEALTH INFORMATION FORM

Patient Name: ______________________________ SS#: ____________________

Telephone: ______________________________ DOB: ____________________

Address: ____________________ City: ______________ State:______ Zip: ______

Name of Healthcare Facility from which Records are Requested:______________________________

Phone: ______________________________ Fax: ______________________________

Address: ____________________ City: ______________ State: ______ Zip: ______

Dates of Service Requested: ____/____/______ through ______/_____/______

Reason for Disclosure: ______________________________

Please include the following information:

	Abstract (All notes & diagnostic results)		History & Physical Notes
	Consultation Notes		Progress Notes
	Discharge Summary		Operative / Procedure Notes
	Emergency Room Notes		Therapy Notes
	Lab Results		Pathology Results
	Radiology Reports (CT, MRI, X-ray etc.)		Radiology Images (DICOM – CD / DVD)
	Other – specify:		

MAIL INFORMATION TO: **IMA MEDICAL GROUP**

6675 Westwood Boulevard, Suite 475, Orlando, FL 32821

FAX TO: 866-914-1818 **EMAIL: medicalrecords@inhealthmd.com**