BE 21st Century Oncology

MEDICAL RECORDS REQUEST – CONTINUATION OF CARE

REQUEST AND PATIENT IDENTIFICATION

*Date request made: ____________________________

*Urgency of request: Urgent Routine

*Preferred delivery method: Mail Fax Secure email

*Patient Name: (Last, First, MI):____

Patient Alias (Last, First, MI): ____

*Patient's Date of Birth: ________________________

*DATES AND TYPE OF INFORMATION BEING REQUESTED

Date range of information being requested:

All dates Last 2 years Other: ____

Type of Information being requested:

☐Consultation Reports Diagnostic Films Dosimetry Records Laboratory Results Physician Notes
Portal Films/Simulation Films Progress Notes Radiology or Imaging Reports Surgery/Pathology
Complete Medical Record Billing Records Genetic Records
Other (please specify):
____
____

REQUESTING HEALTHCARE PROVIDER'S INFORMATION

*Name of facility: ____

*Mailing address:
____
____

*Requester's name: ____

*Phone: ______________________________________ Fax: ____

Email: ____

*Required