

The Children's Clinic, Inc.

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**REQUESTING MEDICAL RECORDS
FROM A PREVIOUS HEALTHCARE PROVIDER**

This form must be **filled out completely** in order for your request to be forwarded to the doctor listed below. Please print.

Physician/Provider: _____

Address: _____

Phone Number: _____

Fax Number: _____

Patient Name: _____

Date of Birth: _____

I am now a patient of The Children's Clinic, Inc. Would you please send a brief summary of my past history and treatment including any immunizations, laboratory tests, or x-ray studies that may have been performed to The Children's Clinic.

Thank you for your cooperation.

Signed by: _____
Signature of Patient or Legal Guardian *Date*

Print Name of Patient or Legal Guardian

Relationship to Patient

CONFIDENTIALITY NOTICE

If this is a facsimile transmission, it contains confidential information provided from medical records of The Children's Clinic and is LIMITED to the use of the above named individual / facility. If you are not the intended recipient, you are hereby notified that any divulgence to other parties without specific consent of the patient/guardian constitutes a breach of confidentiality. If you have received this transmission in error, please notify us by phone to arrange for the return of the documents. Thank you.