The Children's Clinic, Inc.
4001 Dale Street Suite 213
Anchorage AK 99508-5496
Telephone: (907) 562-2944
Fax: (907) 562-6321

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