



# TAMPA PAIN RELIEF Center

## MEDICAL RECORDS REQUEST FORM

REQUEST DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_

### TYPE OF REQUEST: (please check mark your choice below)

- ALL OFFICE NOTES, MRI'S REPORTS AND MISC. DOCUMENTS
- ONLY THE FOLLOWING SPECIFIC DATES OF SERVICES
- COPY OF THE MRI REPORT AND CD COPY OF THE MRI IMAGES  
DATE OF MRI: \_\_\_\_\_
- LIST OF MEDICATIONS OR A SPECIFIC PRESCRIPTION

### FOR PURPOSE: (please check mark your choice below)

- ATTORNEY  
NAME: \_\_\_\_\_  
PHONE: \_\_\_\_\_
- DISABILITY
- OTHER PHYSICIAN USE

### DISTRIBUTION:

MAIL TO PT'S HOME ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

FAX TO PHYSICIAN #: \_\_\_\_\_

PT WILL PICK UP at HABANA / FLETCHER ON: \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

Please note there is a minimum of 72 hours prior request time required for records and 48 hours prior request time for copies of MRI CD. Records cannot be copied on the same day they are requested, please make arrangements if needed for a Dr's appointment. THANK YOU.