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Medical Records Request

A patient, or his/her legal representative, may inspect and/or obtain a copy of their medical records, or have copies of medical records sent to another facility. USMA requires a completed and signed Medical Records Request form before releasing any documents to anyone, including the patient.

When you complete and sign this form, health information about you will be released as you describe in the form. Please read each section carefully and complete the required sections before signing. Please clearly and legibly print all information when completing this form and sign in the first box.

Patient Name: _____ Date of Birth: _____

Address: _____

Street City State Zip

Patient Signature: _____ Date:_____

☐ To ☐ From

Raphael B. Stricker, M.D.
Melissa C. Fesler, FNP-BC
Union Square Medical Associates
450 Sutter Street, Suite 1504
San Francisco, CA 94108
Phone: (415) 399-1035
Fax: (415) 399-1057

☐ To ☐ From

Patient/ Facility/Provider:

_____

Address Line 1: _____

_____

Phone: _____

Fax: _____

Type of Information: ☐ Copies of Records ☐ Verbal /Communication

☐ **Other (please specify):_____**

Please specify the health information you authorize to be released:
☐ ALL Medical Records
OR Specific Records (check appropriate box):
☐ Office Notes
☐ Lab Results
☐ Other: _____
Specific date(s) of treatment if applicable: _____