Paul Kapsar MSN APN

REQUEST FOR PROTECTED HEALTH INFORMATION FROM ANOTHER HEATH CARE PROVIDER (NOT REQUIRING PATIENT AUTHORIZATION)

Note: Per HIPPAA regulations disclosure of protected health information for the purposes of treatment, payment of healthcare operations does not require patient authorization.

DATE:_____

TO: Name _____
Who we need to obtain records from

Address_____ FAX#:_____

City State Zip_____ PHONE:_____

FROM: ***SilverArc APN*** FAX: ***702-463 5197***

2840 East Flamingo Road Suite C Las Vegas, NV 89121

CONTACT: Paul Kapsar APN PHONE: 702 202 2631

We are requesting copies of medical records on the below referenced patient. These records are being requested for treatment, payment or healthcare operations.

Except for emergency**, copies of medical records exceeding ten (10) pages are to be mailed to the requestor's address above. Thank you**

Patient Name at time of treatment:	Birthdate: ___/___/____	Social Security Number: XXX-XX-_____
Street Address: City: State: Zip Code:		
For treatment date:		
Type of Access Requested: (**X**) Copies of medical records ( ) Review	Specific Portions Needed: o Abstract/Pertinent o Emergency Room o H&P, D/C Summary o Consult Report o Operative Report o Rehab Services	