



Medical Record Request ID#: _____

Pet's Name : _____ Date: ____/____/____

Owner's Name : _____

Request

Reason for this request: _____

Inactivate Chart? : No Yes Reason: _____

Please send records to (Name): _____

Fax #: _____

e-mail address: _____

Client to pick up records in person

Provide vaccination summary

Provide computer patient summary of services for the last year

Copy chart from dates _____ to _____ at \$0.50 per page + postage

You may charge my credit card :

MasterCard American Express

Visa Discover

Name on Card: _____

Card #: _____ CVC: _____ Exp: _____

Billing Address: _____

_____ Zip: _____

X _____ / /
Owner's Signature Date

fax signed form to 949.459.7738

Hospital Use Only Medical Record Review Checklist (check & initial each box)

_____ Verified client's Accounts Receivable balance is \$0.00

_____ Checked No Service Accounts & client has not been sent to collections

_____ Obtain client signature in space provided above

_____ Print computer patient summary of services

_____ Chart reviewed by OM & copies made Date : _____

_____ Copies reviewed by Doctor: _____ Date : _____

_____ Records mailed/retrieved by client. Time: _____ Date : _____

_____ Client/Pet(s) inactivated (if applicable)

_____ Put this form in OM locked file and note on chart.

Request Taken By: _____ Date ____/____/____

Request Completed By: _____ Date ____/____/____