Request to Obtain Medical Records

This authorization is necessary for us to comply with state and federal laws pertaining to the request and or release of medical records regarding the patient identified below. Please provide all of the requested information. Failure to provide all requested information may prevent Blackhawk Medical Group from acting on this request.

Patient Name ____ Date of Request ____/____/____

Date of Birth _____/_____/_____

Person Authorized to Request Medical Records
(Patient, Parent or Guardian)

Name ______________________________
Address ______________________________
City, State, Zip ______________________________
Phone ______________________________

Please send this authorization to:

Dr/Hospital ______________________________
Address ______________________________
City, State, Zip ______________________________
Phone ______________________________
FAX: ______________________________

Please Send My Medical Records To:

Blackhawk Medical Group

4165 Blackhawk Plaza Circle Suite 100

Danville, CA 94506

Phone: 925-736-7070 **FAX: 925-736-7075**

Information to be sent:

_____ All Medical Records
_____ Only those checked below during the date range specified here: ______________________
_____ Billing Records _____ EKG/TMT Results _____ Medications
_____ X – Ray Results _____ History & Physical _____ Lab/Pathology
_____ Progress Notes _____ Immunizations _____ Reports
_____ Other ____

____Date ____/____/____
Patient or Authorized Signature

03/2018 Rev