Brian S. Shah, M.D.

RECORDS OR REPORT REQUEST

Complete a separate form for each request.

Date:_____

Patient Name:_____ Contact #:_____

Date of Birth: _____ Email: _____

Type of Report Needed:

___ Doctor Referral Request
___Chiropractor/Physical Therapist
___ FMLA/Disability
___ Attorney Request
___ Insurance ID #_____ Group#_____
___ Other

Type of Records Needed: (Please note there might be charge depending on the type of records request)

___ Consultation Records
___ CT Report
___ Surgery Records
___ Entire Chart
___ Medical Clearance
___ Other (Please describe below)

If seeing a medical provider when is your appointment scheduled? _____

In detail, describe what you are requesting:_____

_____

_____

_____

To: Dr. Mr. Ms. Mrs.
Address:

_____ Phone #: _____
_____ Fax #: _____
_____ Email: _____
_____ __ **encrypted** __**unencrypted**

My signature gives my consent for this report or medical information to be shared with each person listed on this form. By signing, I also understand that I may have a preparation and/or handling fees for this report. I agree to pay any associated fees prior to the completion of the request.

_____ _____
Signature Date

Please allow seven (7-10) Business days to process this request, unless urgent.

For employee use only

Date of request:_____	Total Amount Due: $ _____	Date Request Sent:
Employee: _____	Date Payment Received: _____	_____
Fee for service: YES NO TBD	Employee: _____	Employee: _____