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# PATIENT INFORMATION:

**Center for Orthopedic Excellence**

1008 Tavern Rd., Suite 102

Martinsburg, WV 25401

Office (304) 263-5129

Fax (304) 263-3726

NAME: DATE OF BIRTH:

SSN # STREET ADDRESS:

CITY, STATE, ZIP:

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# REQUEST FOR MEDICAL RECORDS TO BE TRANSFERRED:

**TO / FROM (circle)**

Health Care Facility Physician Self Lawyer Other

NAME:

ADDRESS:

CITY, STATE, ZIP:

PHONE: FAX #

COMPLETE MEDICAL RECORD \_\_\_\_\_\_\_\_XRAYS ON CD

OR JUST THE FOLLOWING CHECKED ITEMS:

**\_\_\_\_\_**OFFICE NOTES \_\_\_\_\_LAB REPORTS \_\_\_\_MRI REPORTS X-RAY REPORTS

\_\_\_\_\_\_SURGICAL REPORTS \_\_\_\_\_PHYSICAL THERAPY NOTES

OTHER

FOR THE DATE TO INCLUDE TO OR \_\_\_\_\_\_ALL TIME

Please note that there is a $10.00 processing fee for each request and a $5.00 fee for Xray CD.This process usually takes from 2 – 5 business days.

PATIENT / PARENT / GUARDIAN SIGNNATURE DATE