EMERGICON
emergency medical billing

Patient Records Request Form

Name of Patient: ____

Date of Service: ____

Date of Birth: ____

SS#: ____

List the location you would like the records mailed, faxed, or emailed to:

Name of Person to Release information to: ____

Address: ____

City:__________________________________ **State:** ______________ **Zip:** _________________________

Phone #: ______________________________ **Email:** ____

Fax #: _________________________________ **Relationship to Patient:** _____________________________

Date

Thank you,

____
Signature

____
Printed Name

Medical Records
877-602-2060 ext.1611

Return via:
email:
records@emergicon.com
fax: 1-800-608-9457or
mail to:
PO Box 180446
Dallas, TX 75218

PLEASE PROVIDE A COPY OF PATIENT ID FOR VERIFICATION. IF PATIENT IS DECEASED, PLEASE PROVIDE A DEATH CERTIFICATE NAMING YOU AS A SPOUSE, PARENT, OR DEPENDENT OR SEND THE FIRST PAGE NAMING YOU IN CHARGE OF THE ESTATE OR EXECUTOR OF THE WILL ALONG WITH A COPY OF YOUR ID. IF YOU HAVE A POWER OF ATTORNEY TO ACT ON THE PATIENT'S BEHALF, PLEASE SEND A COPY WITH A COPY OF YOUR ID