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:** _____

Thank you,

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

Date

_____

Signature

_____

Printed Name

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