Eisenman & Eisenman M.D.
ADVANCED GASTRO CONSULTANTS
Jesse Eisenman, M.D. | Richard Eisenman, M.D. | Cathia Rene, M.D.
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Phone: 561.753.7487 Fax: 561.753.8161

MEDICAL RECORDS REQUEST

TO: _____ FAX #: _____

RE: Patient: _____ DOB: _____ LAST 4# SS: _____

Our office is treating the above listed mutual patient and we are requesting a copy of the following medical information if previously ordered/applicable.

_____ Recent Lab/Blood Work
_____ CT Scan Results
_____ MRI Results
_____ PET Scan Results
_____ Ultrasound Results
_____ Office Notes
_____ Surgical Note with Pathology (if applicable)
_____ Colonoscopy / Upper Endoscopy Report with Pathology
_____ Recent EKG
_____ Medication List
_____ Other: _____

Medical Release Authority: I, _____, (patient or legal guardian) hereby requests that you release the above information as well as any other pertinent data regarding my treatment: From effective dates: _____ to _____.

Please release to the practice of Eisenman & Eisenman, M.D., Advanced Gastro Consultants, in whole or in part. Fax: 561.753.8161 Address: 5065 State Rd. 7 Suite 201, Lake Worth, FL 33449.

Patient Signature: _____Date of Request: _____

Witness: _____Date: _____