Farshid Sam Rahbar, M.D., FACP
Diplomate American Board of Internal Medicine and Gastroenterology
(310) 553-4400

Request for Medical Records

Please respond to each question below and provide a method of payment:

Patient Name(Please print legibly):	
D.O.B./Last 4 of Social Security/other form of ID:	
1. Individual Requesting Records:	
2. Reason for Requesting Records:	

3. If not the patient, are you the parent? ☐ Yes ☐ No

4. Are you the legal guardian? ☐ Yes ☐ No
(We may require proof of legal guardianship)

5. What records are you requesting? ☐ Operation Reports ☐ Office Notes
☐ Lab Results ☐ Hospital Records ☐ All Medical Records ☐ Other:________________

6. Who will receive the records?
☐ Patient
☐ Parent/legal guardian: ________________
☐ Other(please explain): ________________

7. How will you receive them?
☐ Pick up CD at office – Pay $25 - requires ID at time of pick-up
☐ Mail CD – Pay $31 - *includes shipping & handling*
*please provide shipping address at left:
☐ Pick up paper copy - $25 handling fee plus 25¢ per page
☐ Fax a copy - $25 handling fee plus 10¢ per page
☐ I want my records expedited in less than 48 hours – $15 fee

***Shipping Address (if by mail):**

Note: Please send check or other method of payment along with this form. Complete attached credit card form if paying by credit card.

***__Please pay any outstanding balance prior to collecting your medical records.__**

Signed: **Date:**

Printed:

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info@LAIntegrativeGI.com

Credit Card Information

If paying by credit card, please fill in the required information below to secure payment and include it with your Request for Medical Records form.
If paying by other means, you may disregard this form.

Patient Name:	Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ AMEX
Card No:	Exp. Date:
Signature:	3-4 Digit Security Code:
Date:	Amount to be Paid: $