Transitional Care Management Medical Records Request

This form should be utilized for Transitional Care Management.

Practice Name _____

Street Address _____

City, State, ZIP_____

Phone Number _____ Fax Number_____

Request for Clinical Information from:

_____

NAME OF PHYSICIAN/PRACTICE/HOSPITAL

Date of Service _____

RE: Patient Name_____ Date of Birth _____

Dear Colleague:

The patient listed above is being seen in our office by _____. In order to provide appropriate care for our mutual patient, we need additional clinical information from you. Please note, this limited sharing of information for direct patient care is exempt from HIPAA regulations and does not require a signed consent from the patient.

_____ Most recent radiology report

_____ Most recent office visit note

_____ Most recent mammogram

_____ Most recent colonoscopy

_____ Most recent pap smear

_____ Other:_____

_____ Other:_____

_____ Pathology

_____ Most recent eye exam

_____ Vaccine records

_____ Most recent labs

_____ Hospital/ER discharge summary

_____ Other:_____

_____ Other:_____

Please fax this clinical information as soon as possible to (____) _____. If you have any questions or need additional information, please call (____) _____.

Thank you for your assistance,

_____

PRACTICE CONTACT

_____

PHONE NUMBER

_____

EMAIL ADDRESS