REDEFINE HEALTHCARE
ORTHOPEDIC PAIN & SPINE CENTER

ORTHOPEDIC PAIN AND **SPINE CENTER**

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REQUEST FOR COPY OF MEDICAL RECORD

I, _____, date of birth _____/_____/_____, and residing at _____, _____, _____ request that Freeman Spine & Pain Institute provide me with a copy of the following documents from my medical record.

[ ] COMPLETE RECORD
[ ] Progress Notes
[ ] Procedure Reports
[ ] History & Physical
[ ] Radiology Reports
[ ] Diagnostic Reports
[ ] Physical Therapy Reports
[ ] Laboratory Results
[ ] Billing record
[ ]_____ (other, specify)

_____ _____
Signature of Patient of Legal Representative Date

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ACKNOWLEDGMENT OF RECEIPT OF COPY OF REQUESTED MEDICAL RECORD

I hereby acknowledge that I have this date received a copy of the above-requested documents from my medical record.

_____ _____
Signature of Patient of Legal Representative Date