

REQUEST FOR RECORDS

Date: _____

Doctor: _____

Address: _____ Suite: _____

City: _____ State: _____ ZipCode: _____

I authorize you to furnish the following information regarding my condition, history, findings and diagnosis. Please send copies today:

By Mail

Nalini Chilkov, O.M.D.
530 Wilshire Blvd. Suite 206
Santa Monica, CA 90401-1421
(310) 395-4133

By Fax

(310) 451-3975

OR

By Email (PDF)

frontdesk@healthtools.com

Please send records for the period _____

Laboratory Reports

Pathology Reports

Radiology Reports

Surgical Reports

Treatment Notes

Other: _____

Patient Name

Patient Signature (Parent if Patient is a Minor)

Date of Birth

Social Security Number

Address

Phone

City State Zip Code

Fax

Thank you for your prompt attention to this matter!!!