Request for Patient Information Form

Patient Name: ____

Last Name First Name MI

Address:

DOB:

Social Security Number:

1. Persons/Organization Requesting Information:

Stat! Cardiologist Inc. / Saifullah Nasir, M.D.
2425 W. 22nd Street, Suite 209 , Oak Brook, IL 60523
Phone: 630-451-9694 , Fax: 630-931-3330

2. Information Requested From:

Name:_________________________

Address:________________________

____

Telephone #: ____________________ Fax#: _________________

3. Information to be disclosed:

☐ Pertinent Summary (includes all *items below if contained in the record)		
☐ Admission Form	☐ *Special Procedure	☐ Respiratory Report
☐ *Facesheet	☐ *Pathology report	☐ Medications / treatment report
☐ *Discharge Summary	☐ *Cardiac Cath Report	☐ Nurses Notes
☐ *Emergency Room Report	☐ *Lab Reports	☐ Entire Record
☐ *History & Physical	☐ *Radiology Report	☐ Other __________________
☐ *Consultation Record	☐ *EKG Report	
☐ *Operative Report	☐ *EEG Report	

____ ____________________

SIGNATURE OF PATIENT DATE

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PRINTED NAME OF LEGAL REPRESENTATIVE

____ ____________________

SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE DATE

☐ Guardian ☐ POA
☐ Executor ☐ Person Responsible for Estate