

Carnahan Therapy/ The Work Center, Inc.

805- East Walnut Avenue

Lompoc, California 93436

P.T. Office: 805-735-3714 O.T. Office: 805-737-4604

Request for Copy of Medical Records

Date: _____

To: _____

Fax Number: _____

From: Receptionist

Return Fax: 805-736-6392

Re: _____

Date of Birth: _____

The above-mentioned patient is being seen for physical/ occupational therapy in our clinic. To assist our therapist with performing a thorough evaluation, or obtaining authorization for treatment for worker's compensation we are requesting a copy of the following reports:

_____ X-ray of (body part) _____

_____ MRI of (body part) _____

_____ CT Scan of (body part) _____

_____ Surgical Report (date of surgery) _____

_____ Other _____

I give my permission for the above-mentioned facility to release these records to Carnahan Therapy. (A copy of this authorization is as effective as the original).

Signed: _____ Date: _____

This communication, including attachments, is for the exclusive use of the person or entity to which it is addressed and may contain confidential, proprietary and/or privileged information. Any review, retransmission, dissemination or other use of/ or taking of any action in reliance upon, this information by persons or entities other than the intended recipient is prohibited. If you receive this fax in error, please contact the sender immediately.