Gordon Medical Associates

3471 Regional Parkway
Santa Rosa, CA 95403
707.575.5180
fax 707.575.5509

www.gordonmedical.com
info@gordonmedical.com

Records Request Form (to GMA)

I, _____, Date of Birth, ____/____/_____, hereby request:

Doctor's Name: _____

Address: _____

_____

City, State & Zip: _____

Phone _____ Fax: _____

to release and provide a copy of the following

		All	From
☐	Complete medical records (all of below)	☐	_____ to _____
or			
☐	Patient progress notes	☐	_____ to _____
☐	Lab tests	☐	_____ to _____
☐	CAT scans, US, MRIs and X-rays	☐	_____ to _____
☐	Medications/supplements		

for the purpose of providing information that may benefit my treatment. Please send my records to:

Gordon Medical Associates
3471 Regional Parkway
Santa Rosa, CA 95403
Phone: 707-575-5180 **Fax: 707-575-5509**

Send my records via: ☐ Fax (no more than 10 pages) ☐ 1st Class mail

Signature: _____ **Date:** ____/____/_____