

## Gordon Medical Associates

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www.gordonmedical.com  
records@gordonmedical.com

### Records Request Form

I, \_\_\_\_\_, Date of Birth, \_\_\_\_/\_\_\_\_/\_\_\_\_, hereby request that **Gordon Medical Associates** please release and provide a copy of the following, for the purpose of providing information that may benefit my treatment. I am aware that I may rescind this permission at any time in writing:

	<u>All</u>	<u>From</u>
<input type="checkbox"/> Complete medical records (all of below)	<input type="checkbox"/>	_____ to _____
<i>or</i>		
<input type="checkbox"/> Patient progress notes	<input type="checkbox"/>	_____ to _____
<input type="checkbox"/> Lab tests	<input type="checkbox"/>	_____ to _____
<input type="checkbox"/> CAT scans, US, MRIs and X-rays	<input type="checkbox"/>	_____ to _____
<input type="checkbox"/> Medications/supplements		

<b>Specific Authorization: (initial all that apply)</b> I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law and that is applicable to EITHER or ALL of these items. My signature below authorizes releases of all such information.	<input type="checkbox"/> HIV test results <input type="checkbox"/> Mental health treatment <input type="checkbox"/> Alcohol/drug treatment
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Please send my records to:

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**City, State & Zip code** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Fax** \_\_\_\_\_

Record Requests are processed **WITHIN 5 – 7 BUSINESS DAYS**. *3-Day Rush-Processing is available for an additional fee of \$35.* Messages can be sent to the Records Department via [records@gordonmedical.com](mailto:records@gordonmedical.com) or (707) 575-5180 Option 7 (voicemail).

Please send my records via:  Fax (no more than 10 pages)  1<sup>st</sup> Class mail

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_



Unravelling Complex Chronic Illness