
Gordon Medical Associates

3471 Regional Parkway
Santa Rosa, CA 95403
707.575.5180
fax 707.575.5509

www.gordonmedical.com
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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

- | | <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 | | |

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: ____/____/____



Unravelling Complex Chronic Illness