Santa Margarita Animal Care Center Medical Records Request

Date:_____

Client Name:_____Client ID#_____

Contact Phone Number(s):_____

Pet Name(s):_____

Reason for request (please be specific):_____

_____

Inactivate chart: No ☐ Yes ☐ Reason: _____

☐ Fax to client Name:_____ Fax#:_____

☐ Mail to client Name:_____ Address:_____

☐ Client to pick up records _____

☐ Please provide a vaccination summary @ no charge.

☐ Please provide a computer patient summary of services for the last year @ no charge.

☐ **Client Signature:**_____ **Date:**_____

☐ Please copy chart from dates_____ to _____ @ $.50 per page + postage.

You may charge my credit card: ☐ MC ☐ Visa ☐ AMEX ☐ Discover

Card #: _____

Expiration Date: _____ Security Code: _____

Billing address #: _____ Billing zip code: _____

Name as it appears on card: _____

Signature: _____

Please fax signed form to 949-459-7738

For Hospital Use Only

Medical Record Review Checklist (check & initial each box)

☐ _____ Verified that client's Accounts Receivable balance is $0.00

☐ _____ Checked No Service Accounts & client has not been sent to collections

☐ _____ Obtain client signature in space provided above

☐ _____ Print computer patient summary of services

☐ _____ Chart reviewed by OM & copies made Date_____

☐ _____ Copies reviewed by Doctor:_____Date:_____

☐ _____ Records mailed/picked up by client. Time:_____Date:_____

☐ _____ Client/Pet(s) inactivated (if applicable)

☐ _____ Put this form in OM locked file and note on chart.

Request Taken By:_____ _____

Name Date

Request Completed By: _____ _____

Name Date