

PATIENT RECORDS REQUEST FORM

Dr. Radu V. Wolf
7935 216th Street S.W. Suite A
Edmonds, WA 98026
(425) 778-0600/(425) 673-7808

Name of Patient Whose Record is Requested _____

DOB _____ Phone _____

Address _____ City/State/Zip _____

Please provide a copy of a record as indicated below:

- The full health record maintained by this provider/practice
- The health record for the following time frame: _____ through _____
- A summary of the information requested above is adequate for fulfill this request.

Signature of Patient _____

Signature of Authorized Personal Representative _____

Relationship to Patient _____

Date _____