Baptist
Physician Network
Affiliated with Baptist Hospitals of Southeast Texas
Performing Sacred Work Everyday

Medical Record Request Form

Patient Identification – Please Print

Full Name:_____ Date of Birth:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home Telephone #: (_____) _____-_____ Cell Phone #: (_____) _____-_____

Information To Be Released – Covering the Periods of Healthcare

From (date):_____ To (date): _____

Type of Information To Be Released – Please Check Only Those That Apply

___Complete Health Record ___Photographs, videotapes ___X-ray reports

___History and Physical exam ___X-ray films / images ___Complete billing record

___Laboratory test results ___Consultation reports ___Discharge summary

___Progress Notes ___Other, (please be specific):_____

Purpose of Request

___Treatment or Consultation ___At the request of the Patient ___Billing or Claims Payment

___Other, (please be specific):_____

Where to Send Information

Practice Name: **Baptist Physician Network Gastroenterology Center**

Address: **740 Hospital Drive, Suite 230**

City: **Beaumont** State: **Texas** Zip: **77701**

Telephone #: **(409) 212-6900** Fax #: **(409) 212-6911**

What Practice are We Requesting Records

Practice Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone #: ( ) _____-_____ Fax #: ( )_____-_____

Signature of Patient or Personal Representative

I authorize the release of this information to Baptist Physician Network

I authorize Baptist Physician Network to request the protected health information specified above

Signature:_____ Date:_____

Signing Authority:_____ Relationship:_____