STEVEN CHUDIK MD

SHOULDER & KNEE INJURY CLINIC

Medical Records Request Form

Patient Name:_______________________________________ Date of Birth:___/___/___

Address:____

City:_____________________________ State:_______________ Zip:_____________

❑ Home Phone:__________________ ❑ Cell/Work Phone:______________________

Check the box to indicate which phone number should be called if there is a question with this request and to notify you when the request is fulfilled.

Name of person completing form if not patient: ________________________________

Relationship to patient:____

Is this a Worker's Compensation records request? ❑ Yes ❑ No

Medical Records Requested

Please indicate what records you need and the approximate date of treatment provided for each record so we can fulfill your request in a timely manner. Please note a fee may be charged*.

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Patient (parent/guardian) signature ____

on this day,_____________________________, hereby give my permission to Dr. Steven Chudik, Steven Chudik MD Shoulder and Knee Injury Clinic and/or Hinsdale Orthopaedics to release my medical records specified above to the following individual or company:

____

*A service fee may be charged depending upon the complexity of the request, or the amount/ type of information required. Someone from Dr. Chudik's office will call you if there will be a charge and inform you of the amount.

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