ELITE MEDICAL CENTER مركـــز إيليـيـــت الطـبّـــي

Medical Record Request Form

- Please read the instructions and fill all the information requested before applying
- If you are a representative or parent/guardian , please specify in the requester information section and fill all the blanks and sign before applying
- Please make sure you have read and filled all the information requested,sign,and pay the request of medical records fees, before submitting the request

Patient Information	
Patient's Full Name:	
Date of Birth (mm/dd/yyyy):	
Patient's **Q**ID Number (**or passport # if not resident**):	
Address:	
Phone Number:	
Email Address:	
Requestor's Information (if not the patient-)	
Full Name:	
Relationship to the Patient:	
Phone Number:	
Email Address:	
Address (if different from patient):	
Types of Records Requested	**Purpose of the Request**
☐ Clinical Notes ☐ Laboratory Test Results ☐ Imaging Studies (e.g., X-rays, MRIs) ☐ Prescription Records ☐ Immunization Records ☐ Entire Medical Record ☐ Other ☐	☐ Personal Use ☐ Continuation of Care ☐ Legal Matters ☐ Insurance Claim ☐ Other:
Preferred Delivery Method	
☐ Electronic Delivery (Email) ☐ Access via Patient Portal	☐ Mail Physical Copies ☐ Pick-Up in Person
Email Address / Pick-Up Details:	
Date :	
Name and signature of requester :	