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MEDICAL RECORDS REQUEST FOR
ORIGINAL PAPER CHART

PATIENT INFORMATION:

Patient's name _____
Date of Birth _____
Address _____
_____ Phone _____

GUARDIAN INFORMATION: (if under 18 years of age)

Guardian's name _____
Address _____ Phone _____

Date original paper chart was requested _____

By whom was the original paper chart picked up _____

Relationship to patient _____

Signature _____ Date _____

Witness Signature _____ Date _____