Mobile Healthcare Solutions, LLC

Phone: (561) 215-7151
Fax: (717) 674-4067
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Request for Medical Information

To: _____
(Name of Provider, Clinic or Specialist)

Phone Number: _____ Fax Number: _____

Patient Name: _____

Date of Birth: _____ Last 4 digits of SSN: _____

Records Requested:

Labs: _____ MRI/CT/US/X-ray: _____ Office Notes: _____

EKG: _____ Other: _____

Please send the requested information via Fax to (717) 674-4067.

I understand that I have the right to revoke this authorization in writing at any time. I also understand that the two exceptions to the right to revoke are: (1) where the provider has acted in reliance upon the authorization, (2) if the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy. I also understand that the information disclosed pursuant to this authorization is effective for the release of information prior to the date it has been signed and unless otherwise indicated, this authorization will expire in six (6) months. I hereby authorize the release of the requested medical information.

Patient Signature: _____ Date: _____