PLEASE COMPLETE ALL HILIGHTED AREAS.

REQUEST FOR MEDICAL/DENTAL RECORDS OR INFORMATION

REQUESTING ACTIVITY - Complete Items 1 through 10 *(Except 8b)*; also complete Item 19.
ADDRESSEE - Complete Items 8b, 11 to 14 or 15 to 18, as appropriate, final referrer shall return to requester.

DATE

1. PATIENT *(Last Name - First Name - Middle Name)*

2. ORGANIZATION AND PLACE OF TREATMENT
NAVAL HEALTH CLINIC ANNAPOLIS
BRANCH OF SERVICE _____.

3. STATUS ☐ MILITARY ☐ VA BENEFICIARY ☐ DEPENDENT ☐ FEDERAL EMPLOYEE ☐ OTHER *(Specify)*

3a. NAME OF SPONSOR *(If dependent)*

4. TO

NAVAL HEALTH CLINIC ANNAPOLIS
695 KINKAID ROAD
ANNAPOLIS, MD 21402
O: 410-293-3610
F: 410-293-2615

5. IDENTIFYING INFORMATION
a. DOD ID NUMBER
b. GRADE/RATE
c. SOCIAL SECURITY NO *(SSN OF SPONSOR)*
d. VA CLAIM NUMBER
e. DATE OF BIRTH

6. DATES OF TREATMENT *(Inclusive)*

7. DISEASE OR INJURY (*UNLESS ORDERING ENTIRE RECORD*)

8. a. RECORDS REQUESTED

MIL	VA	
☐	☐	CLINICAL
☐	☐	OUTPATIENT
☐		HEALTH RECORD
☐	☐	DENTAL RECORD
☐	☐	X-RAY (NO imaging radiology report only)
☐		MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS
	☐	ABSTRACT OF RATING SHEET
☐	☐	REPORT OF PHYSICAL EXAMINATION
☐		ALL AVAILABLE RECORDS . *(Except radiology imaging.)*
☐	☐	OTHERS *(List under remarks)*

WE DO NOT HAVE ACCESS TO INPATIENT / SURGICAL RECORDS AS WE ARE AN OUTPATIENT FACILITY. DENTAL RECORDS MUST BE REQUESTED THROUGH THE DENTAL OFFICE. RADIOLOGY IMAGING NEEDS TO BE REQUESTED THROUGH RADIOLOGY.

9 REMARKS

ALLOW ***2-4 WEEKS*** TO PROCESS YOUR RECORDS REQUEST.

FORMAT OF REQUESTED COPY (*TWO* COPIES ONLY)
[ ] PRINT
[ ] EMAIL _____
[ ] CD (password protected)

PHONE # _____

RETIREMENT/SEPARATION DATE _____

10. SIGNATURE

REPLY/REFERRAL

11. TO:

12. REMARKS
☐ RECORDS CHECKED IN 8b FORWARDED.
☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
☐ MORE INFORMATION NEEDED. FURNISH FOLLOWING:

13. SIGNATURE

14. DATE

REPLY/SECOND REFERRAL

15. TO:

16. REMARKS
☐ RECORDS CHECKED IN 8b FORWARDED.
☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
☐ MORE INFORMATION NEEDED. FURNISH FOLLOWING:

17. SIGNATURE

18. DATE

19. RETURN TO: *(Include ZIP Code)*

REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.