MEDICAL RECORDS REQUEST

Office of Alexander S. McLawhorn, M.D., M.B.A.

I, patient ________________________________ , date-of-birth ____________ , am requesting a copy of my medical records from the practice of Alexander McLawhorn, M.D.

I would like my records:

Mailed to the following address ______________________________

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Faxed to the following number (________)_____________________

Please include the following:

Office Note(s)

Operative Report(s)

Radiology Report(s)

Other ____.

Please note: This request DOES NOT apply to radiology images. **All radiology images (X-ray, MRI, CT, Ultrasound, etc.) must be obtained through the HSS Radiology Records Room at (212) 606-1135.**

*****Record requests typically take 5-10 business days.**

_____________________________________ ____________________

Patient Signature Date

This form may be faxed (212) 774-7317 or mailed to Alexander McLawhorn, MD, 535 E. 70th Street, New York, NY 10021