LOS ANGELES INTEGRATIVE GASTROENTEROLOGY & NUTRITION
Farshid Sam Rahbar, MD, FACP, ABIHM

"Whole-Person Approach to Digestive Care"

(310) 289-8000

Patient Request for Medical Records

Please respond to each question below and provide a method of payment

Patient Name (Please print legibly):	
D.O.B./Last 4 of Social Security/other form of ID:	
1. Individual Requesting Records:	
2. Reason for Requesting Records:	

3. If not the patient, are you the parent? ☐ Yes ☐ No

4. Are you the legal guardian?
(We may require proof of legal guardianship) ☐ Yes ☐ No

5. What Records are you requesting? ☐ Operative Reports ☐ Office Notes
☐ Lab Results ☐ Hospital Records ☐ All Medical Records ☐ Other:_____________

6. Who will receive the records?
☐ Patient ☐ Parent/legal guardian:_____________
☐ Other (please explain):______________________

7. Please pay any outstanding balance prior to collecting your medical records.

8. How will you receive your records?

☐ EMAIL YOU A SECURE DROPBOX LINK -- **$35** → **Recommended Option** → **Email:**
☐ PICK UP USB DRIVE AT OFFICE -- **$55** - Requires ID
☐ MAIL USB DRIVE – Pay in advance **$85** → **Shipping Address:**
☐ PICK UP PAPER COPY -- **$55** handling fee plus 25¢ per page
☐ FAX -- **$25** handling fee plus 10¢ per page (Up to 50 pages)
☐ EXPEDITED IN 3 BUSINESS DAYS – ADD ADDITIONAL FEE -- **$25**

Note: Please send check or other method of payment along with this form or complete attached credit card form.

Signature:___________________________________ **Date Signed:**_____________________________

Date Printed:_________________________________

2080 Century Park E. #1804
Los Angeles, CA 90067
Info@LAIntegrativeGI.com
Fax: (310) 203-4592

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Credit Card Information

If paying by credit card, please fill in the required information below to secure payment and include it withyour Request for Medical Records form.

If paying by other means, you may disregard this form.

Patient Name:	**Card Type:** ☐Visa ☐Mastercard ☐Discover ☐AMEX
Card No:	**Exp. Date:**
Signature:	**3-4 Digit Security Code:**
Date:	**Amount to be Paid: $**

Signature: ______________________ **Date Signed:** ______________________

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