LONGETRICS

Medical Records Request Form

Instructions
1. Fill out the Patient Information below. All fields must be filled out.
2. Write a check to Longetrics pLLC for $65.00 (sixty-five dollars)
3. Mail this completed form and check to:

Longetrics
3020 Carbon Place, Suite 101
Boulder, Colorado 80301

4. If all information is filled out and your check is successfully deposited, then all of your medical records will be mailed to the address you provide below. For any bounced checks, there will be an additional $20.00 fee on subsequent Medical Records Requests.

Patient Information
Full Name:
Date of Birth:
Social Security Number:

Address:

Email:
Phone number:

I was a patient at:
- ☐ **Longetrics**
- ☐ **Wonder Medicine or Wander Medicine**
- ☐ **Other** (if from the hospital, please requests records directly from hospital)

Patient or Legal Guardian Signature:_____

Patient or Legal Guardian Written Name:_____

*****Do not leave any fields blank. Write clearly or ideally type your responses*****

website: longetrics.org
email: info@longetrics.org
address: 3020 Carbon Place, Suite 101. Boulder, Colorado 80301