



For office use only

Medical Record Number:

Financial Number:

Date faxed:

Initials:

What was sent:



# Kaleida Health

## PRACTITIONER/PROVIDER FAX REQUEST FOR PATIENT INFORMATION FROM KALEIDA HEALTH

(Request must be accompanied by Practitioner/Provider fax cover sheet.)

**Requested patient information will not be released without this completed form.****\* Indicates field that is required to be completed. Please Print Legibly.**

### Practitioner/Provider Information

* Name of Requesting Practitioner/Provider:	
* Business Name and Address:	
* Telephone Number:	
* Fax Number or Email Address:	

### Patient Identification

* Name of Patient: (first and last name)		
* Patient's Address, Kaleida Health Medical Record Number or Account Number:		
* Patient's Gender and Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
Date of Kaleida Health Service:		

### \* Patient Information Being Requested (please be specific):

Appointment Date: _____
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### \* Reason for Practitioner/Provider Request (select one):

<input type="checkbox"/> Current treating practitioner	<input type="checkbox"/> Current consulting practitioner
<input type="checkbox"/> Covering for a current treating practitioner	<input type="checkbox"/> Covering for a current consulting practitioner
<input type="checkbox"/> Billing for a current treating/consulting practitioner or service provider	
<input type="checkbox"/> Provider of continuing care (ex., nursing home, home care program, hospice)	
<input type="checkbox"/> Other (please explain why you are entitled to the requested information):	

### Information Requested By:

* Name of Person Completing Request Form:	
* Title:	
* Signature:	
* Date of Request:	

InfoClique is a web-based system designed to provide Kaleida Health's patient care partners a secure, central access point for patient information. To apply for access to InfoClique, please go to [www.infoclique.com](http://www.infoclique.com).



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RELEASE OF INFORMATION