For office use only

E-MAIL PRINT RESET

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:	☐ Male ☐ Female	Date of Birth:
Date of Kaleida Health Service:		

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

Appointment Date: _____

*** Reason for Practitioner/Provider Request** (select one):

☐ Current treating practitioner
☐ Current consulting practitioner
☐ Covering for a current treating practitioner
☐ Covering for a current consulting practitioner
☐ Billing for a current treating/consulting practitioner or service provider
☐ Provider of continuing care (ex., nursing home, home care program, hospice)
☐ 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.