



Dr. Mary Pat Lange Dr. Michael Mulhern

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Request for Medical Records

Physician or Hospital Name: _____

Address: _____

Phone #: _____

Fax #: _____

Medical Information to be Released

- Medical records in the last year
- Medical records/correspondence from other physicians
- Surgical procedures of the Eye
- Other

For dates of service from _____ to _____

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Name, Address, Phone # of Personal Representation of Patient:

Personal Representative Signature and Relationship to Patient

Date: _____