ST. PAUL CORNER DRUG
Pharmacy the way it should be. est. 1922
240 South Snelling Avenue ~ St. Paul, MN 55105
Phone 651 698-8859 Fax 651 698-0005

Request for Report of Medical Record

Report is being requested for:

Full Name:_____DOB:_____/_____/_____

Address:_____

City:_____Sate:_____Zip:_____

Telephone: (_____) _____-_____

Time period of record being requested:

Start Date:_____/_____/_____ End Date:_____/_____/_____

Other additional requests:

_____
_____
_____
_____

I understand that a report of medical record can only be given or sent to the person whose information appears on such report or to a parent or guardian in the case of an individual under the age of 18 years old. If you are requesting a report be mailed or shipped to you, include a photocopy of your driver's license or other government issued photo ID along with this request form. Reports can only be mailed or shipped to the address on record. Requests to have a report sent to an alternate address will be denied.

Reports can also be picked up in person at the pharmacy but can only be released to the person whose information appears on the report or the parent or guardian of an individual under the age of 18 years old. Some form of government issued photo identification will be required when picking up your report.

Signature of requester:_____Date:_____/_____/_____

Printed name of requester:_____

Relation to patient:_____