Outside Records Routing Slip

SITE:

NAME:

DATE: **TIME:**

***MEDICAL RECORDS FOR**--*

***PATIENT NAME:**			
***Date of Birth (DOB):**			
***Address (a):**			
***Address (b):**			
***City:**		**State:**	**Zip:**
***Contact Phone(s):**	**Home:**	**Cell:**	
If Patient is a Minor, Name of Parent or Guarantor:			
***Address (a):**			
***Address (b):**			
***City:**		**State:**	**Zip:**
***Phone Number(s)**	**Home:**	**Cell:**	

Required fields

Describe Contents:_____

_____

SEND RECORDS VIA COURIER TO: **Health Information Services, 89 South Patterson Ave.**
***c/o* ROI Department**
Santa Barbara, CA 93111

NOTE:
This form is for records received from an outside provider and determined to be part of Sansum Clinic Health Information Services/Medical Records files (per Policy 12-036) for the individual patient named herein.