Medical Record Request Form

Name: _____

Address: _____

_____

_____

Please note that there is a **$20.00** processing fee that includes mailing the records to your address.

Your primary physician may also have copies of these records.

We do not have copies of your radiographic studies. You may be able to obtain copies of those reports from the facility where they were performed.

Signed: _____ Date: _____

Mail this request with payment to:

George Lian, MD
3104 O Street
#316
Sacramento, CA 95816