

FAX

TO - PROVIDER / FACILITY

NAME

FACILITY

FAX

PHONE

FROM - SENDER

NAME

PRACTICE/FACILITY

FAX

PHONE

PATIENT REFERENCE (DO NOT INCLUDE FULL IDENTIFIERS)

PURPOSE

☐ Referral

☐ Records Request

☐ Lab Results

☐ Prescription

☐ Other

MESSAGE

This fax may contain protected health information intended only for the named recipient. If received in error, notify the sender and destroy all copies.

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