

Date: [Date]

To: [Recipient Name/Facility Name]

Fax/Email: [Recipient Contact Information]

RE: Request for Prior Operative History and Clinical Records

Patient Name: [Patient Full Name]

Date of Birth: [Patient Date of Birth]

Surgical Procedure Scheduled: [Name of Upcoming Surgery]

Scheduled Date of Surgery: [Surgery Date]

Dear Medical Records Department / Dr. [Provider Name],

The above-named patient is currently undergoing a pre-surgical evaluation for an upcoming procedure. To ensure patient safety and proper anesthetic planning, we are requesting copies of the following records regarding their prior surgical history:

- Operative reports for procedures performed on [Dates or Types of Past Surgeries]
- Anesthesia records and recovery room (PACU) notes
- Recent cardiac clearance or stress test results (if applicable)
- Most recent history and physical (H&P)
- Discharge summaries

Please forward these documents to our office at your earliest convenience. Records can be sent via fax to [Your Fax Number] or via secure email to [Your Email Address].

A signed patient authorization for the release of medical information is attached to this request.

Thank you for your assistance in this patient's care.

Sincerely,

[Your Name/Physician Name]

[Your Practice/Facility Name]

[Phone Number]