OUT-OF-STATE SYPHILIS RECORD SEARCH REQUEST FORM

TO: CDPH STDCB ICCR **FROM:** _____

FAX: 916-636-6212 Fax: _____

Phone: _____

Date: _____

RECORD SEARCH DETAILS: *Please complete as much information as possible*
Name of Client: _____
AKA (s): _____
DOB or Age: _____
If Previous HX Claimed by Client, Please Provide the Following:
Provider/Facility: _____
Medical Record Number: _____
Date of Visit/Year: _____
City/State: _____
Other Pertinent Info: Need any Syphilis information: labs, treatments, and diagnosis