

SYPHILIS RECORD SEARCH REQUEST FORM
For Out-of-State Searches

TO: CA STDCB ICCR

FROM: _____

Fax: 916-440-5348

Fax: _____

Phone: _____

Date: _____

RECORD SEARCH

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