

# Medical Record Summary

Patient Information				
First Name	Last Name	Date of Birth	Gender	Patient Identifier
Medical Records Summary Information				
Summary of Patient's Medical Records from _____ to _____				
Completed By		Signature		Completed Date
Chronological Medical Records Summary (Page 1 of __)				
Date/Time	Reference/Page No.	Provider	Encounter Summary	

**Patient Information**

First Name	Last Name	Date of Birth	Patient Identifier
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**Chronological Medical Records Summary (Page \_\_ of \_\_)**

Date/Time	Reference/Page No.	Provider	Encounter Summary