

**Medication Therapy
Management**

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To: _____ Date _____
From: _____ # of pages _____

Request for Information: Patient Release Attached

Your Patient: _____ DOB _____

Please send us a copy of the checked test results:

- CMP (Chem 12) or BMP
- Lipid Profile
- Urinalysis
- A1C
- Uric Acid
- Thyroid Panel
- Bone Density Test
- Lung Function Test

Please indicate Care Goals for checked items:

- Blood Pressure: _____
- Lipids: _____
- A1C: _____
- Weight: _____
- Other: _____

Thank you for your attention to this matter!

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA