UNIVERSITY OF MINNESOTA
MEDICAL CENTER
FAIRVIEW

Date: No. of Pages:

To: Fairview Admissions
FAX: 612-273-6695
Phone: 612-273-6685

From: Name:
Phone:
Department Name:
Fax:

Please assign medical record numbers for the following patients. Thank you.
(Note: Requester *provides all information listed below. Fairview completes the MR# box and returns to requester via fax*)

Expected Timeline: All requests will be completed within 24 hours Monday through Friday.

Patient Name (last, first middle)	Address(Include County)	Phone #	Gender	SS#	DOB	MR#