

Patient Request for Health Information

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:
Name at Time of Treatment (if different than above):		
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):
Street Address:	City:	State: Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ___/___/___ through ___/___/___

- Discharge Summary
 Emergency Room Records
 Operative/Procedure Reports
 Billing Records
 Test Results (X-Rays, Lab/Pathology Results) Please specify: _____
 Other (Immunization Records, Medication Lists) Please specify: _____

How would you like your records delivered?

- Paper
 Home Delivery
 In-Person Pickup
 Electronic (Email, USB, CD, Portal, Other) Please specify: _____

Where do you want the information sent? (Fill in boxes below):

should provide my records to: Self Personal Representative (indicated below)

Recipient Name:	Recipient Phone:
Recipient Mailing Address:	Recipient Fax:
	Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	Relationship (please print)
Signature of Patient or Personal Representative	Date/Time

Please return completed form to:

	E-mail:
	Fax:
	Questions?

*recognizes a patient's right under HIPAA to access copies of his/her health information.
There may be charges associated with processing a request and producing requested records.*