REQUEST FOR MEDICAL RECORDS

PATIENT NAME: ___________________________________ **DATE OF BIRTH:** _____ / _____ / _____

REQUESTING RECORDS FROM:

____
(name of doctor, provider, clinic, or patient)

____
(mailing address)

____
(city, state, zip)

Phone #: ______________________________________

Fax #: ____

PLEASE SEND MEDICAL RECORD TO:

____
(name of doctor, provider, clinic, or patient)

____
(mailing address)

____
(city, state, zip)

Phone #: ______________________________________

Fax #: ____

RECORDS TO BE:

- ☐ **MAILED**
- ☐ **FAXED TO:** ______________________
- ☐ **CALL PT TO PICK UP**
- ☐ **SENT BY CERTAIN DATE** ______________________

ADDITIONAL COMMENTS:

PLEASE INCLUDED THE FOLLOWING RECORDS:

- ☐ Medical records needed for continuity of care (including transcribed medical records, pathology reports, laboratory reports, and diagnostic imaging reports.
- ☐ Other: ____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

- ☐ HIV/AIDs related records
- ☐ Mental health information
- ☐ Genetic testing information
- ☐ Drug and alcohol diagnosis, treatment or referral information (Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Provide a specific description of information on the reverse side of this form.)

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature: _______________________________________ Date: ______________________

- please allow 7-10 business days for medical records -