Name of Health Care Provider or Hospital Medical Records Dept.

Address of Provider

City, State and Zip

RE:

Your Name

Your Date of Birth I"Uqekcn"Ugewtkv{ "Pwo dgt "kh"t gswkt gf

Your Health Plan Number

Your Phone Number

Date of Service (if appropriate)

To whom it may concern:

Today's Date

I am writing y kj regardu to my medical records from your office. I would like to j cxg a copy of my medical records faxed to;

Dr. Altvater C/O Delta 9 Medical Consulting
421 Merrimack Street Suite 101B
Methuen MA. 01844
FAX 800-851-9270 Phone 970-335-8290.

Please include:

1. Current problem list, abstract, and summary of major medical issues, with specific emphasis on the conditions checked below:

- ❑ Chronic pain (of at least 6 months duration)
- ❑ Severe nausea
- ❑ Seizures
- ❑ Severe muscle spasms
- ❑ Wasting syndromes
- ❑ Cancer
- ❑ Glaucoma
- ❑ HIV or AIDS
- ❑ Hepatitis C
- ❑ ALS (Lou Gehrig's disease)
- ❑ Crohn's disease
- ❑ Other debilitating condition"aaaaaaaaaaaaaa

2. Current medication list and drug allergies.
3. Laboratory or written radiology results associated with the current problem list.
4. Prior two visits for condition(s) checked above.

5. I give specific permission to release any information related to:

__ SUBSTANCE ABUSE
__ PSYCHIATRIC/MENTAL HEALTH INFORMATION
__ HIV/AIDS INFORMATION

This authorization will expire sixty (60) days from the date signed. I understand that I make revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon. I understand that if I am releasing this information to an entity or individual not covered by HIPAA, this information is no longer protected by HIPAA.

Patient's or Legal Guardian's Signature ________________________

____
Print Your Name

____
Address

____
City, State, and Zip Code

____
Phone Number

Name at time of treatment, if other than above: ____________________

A patient is entitled to this information per HIPAA privacy rule it allows your office 30 days to provide the records and doctors may not hold medical records because the patient has not paid for services provided. You may charge a reasonable fee for the cost of copying and mailing records – but this request is for a fax of the records only.