Patient Record Request Form

You have the right to inspect and obtain a copy of your medical and billing records that we maintain. If you request copies of your records, we will notify you of any charge.

Patient Information (Individual whose information will be released):

Name: (First, Middle, Last) **Date of Birth:** (Month/Day/Year)

Address:
(Street, City, State, Zip Code)

Description of Requested Records:

Records Requested from: (Date) to: (Date)

Please indicate whether you want to inspect your records or obtain a copy of your records:

☐ Inspect

Obtain a copy on:

- ☐ CD
- ☐ USB Drive
- ☐ Paper Records
- ☐ Secure Message (will require a login)
- ☐ Unencrypted email (by choosing this option, you understand that there is a risk the requested information could be viewed by an unauthorized person when transmitted over the internet)
- ☐ Other preferred form and format:

If you are requesting to obtain a copy:

☐ For pickup

☐ Mail to the following physical address:

Name

Street City State Zip Code

☐ Email or send secure message to the following email address:

_____

Print Name:

Relationship (if authorized representative of patient):

Signature: **Date:**

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the patient (e.g. Health Care Power of Attorney).