Patient Request for Health Information

Patient Information

First Name:	Middle Initial:	Last Name:	Date of Birth:
Street Address:			
City:		State:	Zip:

Facility Information

Clinic/Hospital Name:			
Street Address:			
City:		State:	Zip:

Check any information that you would like:

- ☐ Office Notes
- ☐ Imaging Reports
- ☐ Medications
- ☐ Procedures / Operative Notes
- ☐ Lab / Test results (Blood tests, Urinalysis, etc.)
- ☐ Immunization Records
- ☐ Other (specify): _____

Which types of sensitive information do you authorize for release?

- ☐ Genetic / Hereditary Test Results
- ☐ Substance Abuse Information
- ☐ HIV Test Results
- ☐ Sexually Transmitted Disease
- ☐ Behavioral / Mental Health Records

(Optional) What's the primary reason for your request? This may help us respond more completely to your request.

_____

What time period are you requesting information from? (Specify a range of dates or write something like "last 2 years")

_____ through _____

How would you like your records delivered? (Select one option)

○ Mail

○ In-Person Pickup

○ Email: _____

Recipient Information (please fill out address even if the delivery method is not mail)

Name or organization:	Phone number:
Street Address:	
City:	State: Zip:
Provide any additional detail or contact information for the recipient below (optional):	

Please print your name and sign below:

Name:	Relationship (if other than patient):
Signature:	Date:
X_____	

Photo of Identification: