



REQUEST TO COPY PROTECTED HEALTH INFORMATION

Patient Name: _____

Acct #: _____

Date of Birth: _____

Patient Address: _____

Street

Apartment #

City, State, Zip

FOR INTERNAL PURPOSES ONLY:

Send medical record to (if different from above):

Name

Street

City, State, Zip

Reason for request _____

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

Instructions for Medical Records Requests

Please mail the completed form to our office. Note that there may be a charge for copies per state Medical Society guidelines. If so, a staff member will contact you to review any charges.