HIPAA COMPLIANT REQUEST FOR MEDICAL RECORDS

DATE OF REQUEST: ____

PATIENT INFORMATION

Patient Name (Print):			
Patient Identification:	Social Security No.	Date of Birth	Medical Record
Reason for Request:			

Name and address of Doctor/Facility where patient's medical records are located:

Name:	
Address:	

SEND THE FOLLOWING RECORDS/REPORTS/FILMS (See Dates):

- ☐ All Medical Records (See below for restrictions) for following dates: ________________________________
- ☐ All Emergency Room Records dated: ____
- ☐ X-Ray/MRI/CT report(s) dated: ____
- ☐ X-Ray/MRI/CT films dated: ____
- ☐ EMG, SSEP, and Nerve Conduction Study Reports dated: ____
- ☐ IME report dated: ____
- ☐ Other:

SEND SPECIFIED AND AUTHORIZED MEDICAL RECORDS TO:

Name:	
Address:	
Telephone:	

I, (Patient Print Name) ____, hereby request and authorize medical records, x-rays, MRI/CT, other films, and tests results to be photocopied, released and mailed to the indicated address above for the specified dates. I understand that the Health Insurance Portability and Accountability Act (HIPAA) applies to my medical records and my protected health information. I expect the holder of my medical records to mail my specified medical records as soon as reasonably possible, not to exceed 30 days, unless my records are off-site which allows for an additional 30 days. This authorization may be revoked by me, at any time, by notifying the doctor's office (privacy officer) of this revocation in writing. I have been advised that if I chose to not authorize that I will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payments.

☐ I HAVE NO PROTECTED HEALTH INFORMATION FOR THE SPECIFIED TIME FRAME release all of my medical records that have been indicated above.

☐ I HAVE PROTECTED HEALTH INFORMATION WITHIN THE AUTHORIZED TIME FRAME release all of the above medical records for the specified time frame except for the following ______________________

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Signature of Patient: ____ Date: ____________________

Expiration Date for this Authorization: ___________________________________