

Patient Request for Medical Records

USE THIS FORM TO REQUEST COPIES OF YOUR MEDICAL RECORDS



PATIENT INFORMATION

Full Name _____

Date of Birth _____

SSN _____

Phone _____

FACILITY WHERE RECORDS ARE NEEDED FROM

Facility Name: _____

If this is for Peninsula and you were in WIT, MAT, IOP, or SOR? Yes No

Please enter dates of service: From _____ to _____

WHAT RECORDS DO YOU NEED?

Examples: labs, X-rays/radiology, surgery notes, office visits, discharge papers, or entire medical record.

**Entire medical record does not include billing records, certain images, or Good Faith Estimates. Psychotherapy records require a different form.*

WHERE ARE THE RECORDS GOING?

Fax

Mail

Email

**If requested, the patient/patient authorized representative consents to receiving protected health information via email and understands that records and messages sent through this type of communication may not be secure.*

Name: _____

Fax Number: _____

Mailing Address: _____

Email Address: _____

I am requesting that the facility named above provide my medical records to me or the person listed above.

Signature _____ Date _____

Printed Name _____ Relationship _____

