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<b>Patient Information (Please Print)</b>			
First Name:		Middle Initial:	Last Name:
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):		Phone:	E-mail (optional):
Street Address:		City:	State: Zip:
<b>What records do you want? (Check appropriate boxes below):</b>			
Date(s) of Service: ___/___/___ through ___/___/___			
<input type="checkbox"/> Progress Notes <input type="checkbox"/> Emergency Room Record <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History and Physical <input type="checkbox"/> Consultation(s) <input type="checkbox"/> Lab Reports <input type="checkbox"/> Pathology Report <input type="checkbox"/> Operative Note(s) <input type="checkbox"/> Imaging/X-Ray Films <input type="checkbox"/> Imaging/X-Ray Reports <input type="checkbox"/> Entire Record <input type="checkbox"/> Fetal Heart Monitor Strips <b>Sensitive Information:</b> <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Communicable diseases, including HIV status <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Psychiatric/Behavioral Diagnoses <input type="checkbox"/> Other (specify) _____			
<b>How would you like your records delivered?</b>			
<input type="checkbox"/> Paper <input type="checkbox"/> Electronic: <input type="checkbox"/> Email (I understand that there is a risk to me when my information is transmitted via an unsecured e-mail system, and the information could be accessed by a third party during the transmission process. By checking the box to request Email delivery I accept this risk.) <input type="checkbox"/> USB or CD <input type="checkbox"/> Password Protected <input type="checkbox"/> Not Password Protected <input type="checkbox"/> Mail to address below <input type="checkbox"/> I will pick up in person			
<b>If mailing, where do you want the information sent? (Fill in boxes below):</b>			
Please provide my records to: <input type="checkbox"/> Myself <input type="checkbox"/> Personal Representative (indicated below) <input type="checkbox"/> Other Third Party			
Recipient Name:		Recipient Phone:	
		Recipient Fax:	
Recipient Mailing Address:		Recipient E-mail (if applicable):	
<b>Please print your name and sign below:</b>			
<b>Name of Patient or Personal Representative (please print)</b>		<b>Relationship (please print)</b>	
Signature of Patient or Personal Representative			Date/Time
<b>Please return completed form to:</b>			
<b>Facility Name:</b>		<b>E-mail:</b>	
<b>Address:</b>		<b>Fax:</b>	
<b>City/State Zip:</b>			
<i>This Healthcare Facility recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.</i>			

Patient Label