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Record Request Form

Patient Information

Name ______________________ DOB ______________________ Date ______________

Name ______________________ DOB ______________________

Name ______________________ DOB ______________________

Name ______________________ DOB ______________________

Who Has Requested The Information

Provider ____

Address ____

Phone ____________________ Fax ______________________

Who Needs The Information

Provider ____

Address ____

Phone ____________________ Fax ______________________

Information To Be Released

____ Office Notes ____Labs ____ Immunizations ____ Billing Records

____ Physicals ____ Growth Charts ____ All Records

Purpose of Release

____ Continuing Care ____ Transfer Care ____ Personal Use ____ Insurance

____ Workers Compensation ____ Attorney ____ Other ___________________________

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPPA identified about disclose full and complete protected medical information including the above.

____ ________________________

Parent, LegalGuardian, or Person Authorized
To sign if other than Signature

Date

____

Relationship to Patient

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS).