Medical Record Request Form

PATIENT INFORMATION

Patient's Full Name: *: _____ Date of Birth: *: _____ dd / mm / yyyy

Patient's ID Number (if applicable): _____ Social Security Number (optional): _____

Address: *: _____ City, State, Zip: *: _____

Phone Number: *: _____ Email Address: *: _____

REQUESTOR'S INFORMATION (IF NOT THE PATIENT)

Full Name: _____ Relationship to the Patient: _____

Phone Number: _____ Email Address: _____

Address (if different from patient): _____

PLEASE CHECK ALL THAT APPLY

Types of Records Requested:

- ☐ Clinical Notes
- ☐ Laboratory Test Results
- ☐ Imaging Studies (e.g., X-rays, MRIs)
- ☐ Prescription Records
- ☐ Immunization Records
- ☐ Entire Medical Record
- ☐ Other

Purpose of the Request:

- ◯ Personal Use
- ◯ Continuation of Care
- ◯ Legal Matters
- ◯ Insurance Claim
- ◯ Other

Preferred Delivery Method:

◯ Electronic Delivery (Email) ◯ Access via Patient Portal ◯ Mail Physical Copies ◯ Pick-Up in Person

Email Address / Pick-Up Details: _____

Authorization: *
Patient of Patient or Authorized Representative: *:

Date: *: _____ dd / mm / yyyy

Relationship to Patient (if not the patient):

Instructions for Healthcare ProviderPlease process this request in accordance with applicable laws and regulations. If there are any fees associated with this request, kindly inform me in advance. The requested records should be provided within the timeframe mandated by law.

OFFICE USE ONLY

Date Received: _____ dd / mm / yyyy

Processed By: _____

Date Fulfilled: _____ dd / mm / yyyy

Method of Delivery: _____

Notes:

CONTACT INFORMATION FOR QUESTIONS OR CONCERNS

Phone: _____

Email: _____

Signature of Witness (if required):

Date: _____ dd / mm / yyyy