

**PATIENT REQUEST FOR RECORDS  
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

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Date: \_\_\_\_\_

Facility Name: \_\_\_\_\_ (Name of physician, hospital or business)

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Dear \_\_\_\_\_: (Contact person if known)

I hereby request copies of medical records for the following patient:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Last Four of SS#: \_\_\_\_\_

Reason for release: (Check one)

Personal Copy     For Another Doctor     Moving     Attorney / Legal     Insurance

Date range of medical records to release: \_\_\_\_\_

Records for release: (Check all that apply)

<input type="checkbox"/> All Records	<input type="checkbox"/> ER Record	<input type="checkbox"/> Outpatient Record
<input type="checkbox"/> Billing Records	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Consults	<input type="checkbox"/> Imaging Reports (X-Rays)	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Cardiology Testing Results	<input type="checkbox"/> Lab Reports/Results	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Discharge Instructions	<input type="checkbox"/> Medication/RX List	_____

Specific confidential medical records authorized for this release:

<input type="checkbox"/> Drug and Alcohol	<input type="checkbox"/> HIV/AIDS Related	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Genetic	<input type="checkbox"/> Mental Health/Psychotherapy	<input type="checkbox"/> Tuberculosis

Release information to: \_\_\_\_\_

Delivery Method:

Through Arctrieval     US Mail     Pick up in person     Fax: \_\_\_\_\_

My relationship to the patient is \_\_\_\_\_ (Only if patient and requestor are different)

If you have any questions or need additional information, please contact me using the information below.

Sincerely yours,

\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_