ID VERIFIED_____
Completed/Not Completed

PATIENT REQUEST FOR HEALTH INFORMATION

Patient Name _____ Date of Birth_____

Address_____

Phone Number_____

Records being requested _____ Date of Service _____

I authorize _____ to pick up my Protected Health Information (PHI)

Description of Health Information to be disclosed: _____

_____

I authorize the provider to use or disclose information related to (initial all that apply):

_____AIDS/HIV or other Communicable Diseases

_____Behavioral Health Care/Psychiatric Care/Mental Health Information

_____Alcohol and/or Drug Abuse Treatment

_____Genetic Testing Information

How would you like your records delivered?

_____Paper _____Electronic (Email, USB Disc) Other_____

_____Pick up by self _____Personal Representative (fill in name of person)

Send to_____

_____

Patient Signature _____ **Date requested**_____

Representative_____ **Date requested**_____

Revised and Approved Date August 22, 2020