PATIENT DIRECTED REQUEST

***Indicates a REQUIRED field.**

Completion of this document authorizes the disclosure and use of health information about you.
Failure to provide all information requested may invalidate this request.

*Patient Name: _____ Medical Record #: _____

*Address: _____ *Date of Birth: _____

*City/State/Zip:_____ Phone: _____

Where do you want the information sent? (This patient directed request is used only when a patient is asking for their own records or directing them to be sent to a third party.)

*Recipient Name:	*Recipient Phone:
*Recipient Mailing Address:	*Recipient Email (if applicable):

***Check Delivery Option:**	❑ Paper Copy / Pick Up or Mail ❑ Providers Fax # _____ ❑ E-Mail (Encrypted/Patient or Continuity of Care Only) _____

***What records do you want? (Check appropriate boxes below):**
Location: _____

Date(s) of Service: ____ / ____ / ____ through ____ / ____ / ____
❑ Discharge Summary ❑ Emergency Room Records
❑ Operative/Procedure Reports
❑ Test Results (X-Rays, Lab/Pathology Results). Please specify: _____
❑ Mental health/Alcohol/drug treatment information
❑ HIV test results ❑ Genetic Testing Information ❑ Reproductive health records
❑ Other (Immunization Records, Medication Lists, Continuity of Care Document). Please specify: _____
_____

I authorize _____ to pick up my medical records.
***Signature:** _____
(Patient/Parent/Conservator/Guardian) Date/Time

*Print Name:_____ Relationship_____

PATIENT LABEL