**Medical Records Request Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, request a copy of the following medical records for:

(Patient/Guardian Name)

Myself Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient Name) (Date of Birth)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Relationship to patient)

|  |  |
| --- | --- |
| Service Dates  All dates of Service  Last 30 days from date of request  Last 90 days from date of request  Last year from date of service  From:\_\_\_\_\_\_\_\_ To:\_\_\_\_\_\_\_\_\_\_ | Information Requested  All Records Radiology Reports  Consultation Assessments  ECG/EKG Reports Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Laboratory Results |

I would like to receive records via:

Mail to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pick up in person (\*requires photo idea verification)

I, the undersigned, authorize Steese Immediate Care, LLC to release the requested medical records via the above selected means. I understand by signing below I am authorizing the release of my Protected Health Information (PHI).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\*Please allow for 3-5 business days for the request to be completed.

\*\*If you are the guardian requesting medical records, we require the requestors name to be listed on the patient’s original intake paperwork.