PATIENT RECORDS ACCESS REQUEST FORM

I hereby request a copy of my medical record as detailed below:

☐ Full Medical Record held by this office

☐ Medical Record for the period of _____ through _____

☐ A specific portion/section of the record as follows:

_____

_____

Please complete below in its entirety

Patient Name: _____

Birth Date: _____

Current Phone #: _____

Name of party requesting records: _____

Relationship to patient: _____

Signature: _____

Date Signed: _____

☐ **I would like for the records indicated above to be mailed to:**

Street address: _____

City, State, Zip: _____

☐ **I would like for the records to be emailed to:**

_____