Patient Request for Health Information Form

_____ *(authorized entity)* recognizes a patient's right of access under HIPAA. There may be charges associated with processing a request and producing requested records.

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

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

Date(s) of Service:____/____/____through____/____/____

☐Discharge Summary ☐Emergency Room Records ☐Operative/Procedure Reports ☐Billing Records

☐Test Results (X-Rays, Lab/Pathology Results) Please specify: _____

☐Other (Immunization Records, Medication Lists) Please specify: _____

How would you like your records delivered?

☐Paper

☐Mail Delivery

☐In-Person Pickup

☐Electronic (Email, USB, CD, Portal, Other) Please specify: _____

Where do you want the information sent? (Fill in boxes below):

_____should provide my records to: ☐Self ☐ Personal Representative (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	**Relationship to Patient (please print)**
Signature of Patient or Personal Representative	**Date/Time**

Please return completed form to: _____*(authorized entity)*

	E-mail: **Fax:** **Questions?**

For internal use by _____ only:

Patient Identification #:	***Date Received:***	***Date Processed:***	***Processed By:***
Fee Charged:	***Were Records Reviewed On-site?***	***Date Reviewed:***	

Authorized Entity: _____

Once completed, please email to: rlott@entclinicmd.com & tcoley@entclinicmd.com