PATIENT ACCESS REQUEST FORM

This Patient Access Request is being submitted to request a copy of patient medical records, as set forth below.
***Note:** Do Not use this form if (a) you are requesting information related to any testing, diagnosis and/or treatment of Alcohol/Substance Use Disorder, Mental Health/Rehabilitation, or HIV/AIDS and (b) you are instructing us to send information to a third party. Please instead use an Authorization to Release Medical information or a comparable form.
***Note:** The Company reserves the right to charge for the production of records, in accordance with HIPAA.

Patient Information

Patient Name: _____ Patient Social Security Number: _____

Patient Address: _____ Patient Date of Birth: _____

Access Details

Name/address of health provider to which this request is directed: _____

_____

Name of person(s) to whom the records should be sent: _____

_____

Method by which the records should be sent (select one):

☐ Mail to the following address: _____

☐ Email to the following email address: _____

☐ Facsimile to the following number: _____

Specific information to be released (check boxes and complete, as appropriate):

☐ Medical Record (including, if applicable: patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers)

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Other: _____

☐ Include the following (*Indicate by Initialing*) (Note: if selected, any such records will only be released to the person signing this form.)

_____ Alcohol/Drug Information
_____ Mental Health Information
_____ HIV-related Information

Signature

_____ _____
Signature of Patient/Guardian/Authorized Representative Date:

If this Request is being submitted by a patient's guardian or authorized representative, please:

Print your name: _____

Describe the basis of your authority to request/receive the above patient's records: _____

_____