Copy of Medical Records

Please give me a copy of my medical records

Clinic Name ____ Date ____________________

Patient Name ______________________________________ Birthdate ________________

Patient Address ____

City ___________________________________ State _____ ZipCode _________________

Patient Email _______________________________________ Phone __________________

Format: __ Paper __ Email If Paper: __ I will pick up __ Mail to me

__ Request copies of my recent patient evaluation on date ________________________

__ Request copies of all my medical information maintained by the practice

When ready, notify me by: __ Text Msg __ Email __ Phone call

Signature of Patient _______________________________________ Date ______________
(or Parent/Guardian)

Internal Use Only

Received By ________________________________ Date ___________________

Privacy Officer Reviewed _____________________________ Date ___________________

Clinician Reviewed ___________________________________ Date ____________________

Comments ____

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Put this completed form in the clinic's Privacy Notebook and the patient's medical record.

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