Online Access to Medical Records

Please give me online access to my medical records

Clinic Name _____ Date _____

Patient Name _____ Birthdate _____

Patient Address _____

City _____ State _____ ZipCode _____

Patient Email _____ Phone _____

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 _____

_____

_____

_____

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