Medical Record Request

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose my full and complete protected medical information to:

Practice/Person: _____

Address: _____

Phone number: _____ Fax number: _____

From:

Practice/Person: _____

Address: _____

Phone number: _____ Fax number: _____

Patient Name: _____ Date of Birth: _____

This disclosure should include:

_____ Office notes; inpatient, outpatient and emergency room treatments; clinical charts; reports; treatment plans; hospital admission records; discharge summaries and test results.

_____ Laboratory records and specimens; radiology records and films.

_____ Prescription records and drug information related to such records.

_____ Billing records, including statements, insurance claim forms, and statements of benefits for the period _____ to _____.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. _____ _____

_____ _____

Signature of Patient **Date**

4510 Medical Center Dr # 208, McKinney, TX 75069 469-742-0199 Phone
972-542-4106 Fax