REQUEST FOR MEDICAL RECORDS

PATIENT REQUEST FOR THE RELEASE OF MEDICAL RECORDS

I, the undersigned Patient (and/or Legal Representative), would like to review following patient records (Specify the patient name, date of birth, and a description of the records requested (including any applicable dates)):

Patient Name: **Address:**	**Date of Birth**

Specific Information to be Released:

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

☐ Entire Medical Record

Retrieval of Requested Information:

☐ I would like my records emailed to: _____

☐ I would like copies of my records sent to the following address(es):

_____ _____

_____ + _____

_____ _____

If request is for insurance purposes please provide an appropriate claim number: _____

For patients requesting their medical records there is no fee. However if you are requesting records to be sent to a third party we would require a HIPAA. If you have any further questions regarding your medical records please email medicalrecords@ivyrehab.com.

Signature: _____ Print Name: _____ Date: _____

If not the patient, name of person signing form: _____

Authority to sign on behalf of patient: _____

Site Location: _____