ROI

Patient Information (Please Print)

First Name: Middle Initial: Last Name:

Name at Time of Treatment (if different than above):

Date of Birth (MM/DD/YYYY): Phone: E-mail (optional):

Street Address: City: State: Zip:

I am requesting my records from:

Facility Name: **Facility E-mail:**

Address: **Facility Fax:**

City/State Zip:

What records do you want to receive or have disclosed to the recipient noted? (Check appropriate boxes below):

Date(s) of Service: ____/____/_____ through ____/____/_____

☐ Progress Notes ☐ Emergency Room Record ☐ Discharge Summary ☐ History and Physical
☐ Consultation(s) ☐ Lab Reports ☐ Pathology Report ☐ Operative Note(s) ☐ Imaging/X-Ray Films
☐ Imaging/X-Ray Reports ☐ Entire Record ☐ Fetal Heart Monitor Strips
☐ Other (specify)_____

_____

If it exists, the following Sensitive Information can be disclosed:

☐ Alcohol Abuse ☐ Drug Abuse ☐ Communicable diseases, including HIV status
☐ Genetic Testing ☐ Psychiatric/Behavioral Diagnoses

How would you like your records delivered?

☐ Paper
☐ Electronic: ☐ Email (I understand that there is a risk to me when my information is transmitted via an unsecured e-mail system, and the information could be accessed by a third party during the transmission process. By checking the box to request Email delivery I accept this risk.)
☐ Removable Media (i.e. DVD, USB, CD-ROM, etc.)
☐ Password Protected ☐ Not Password Protected
☐ Mail to address below ☐ I will pick up in person

If mailing, where do you want the information sent? (Fill in boxes below):

Please provide my records to: ☐ Myself ☐ Personal Representative (indicated below) ☐ Other Third Party (indicated below)

Recipient Name: Recipient Phone:

Recipient Fax:

Recipient Mailing Address: Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print) **Relationship (please print)**

Patient's Signature or Legal Representative — Date/Time

Relationship to Patient / Authority to Act on Patient's Behalf — Interpreter, if Utilized — Date/Time

Witness Signature — Date/Time

This Healthcare Facility recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

Patient Label