Patient Request for Health Information

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:

What records do you want? (Check appropriate boxes below):

Date(s) of Service:____/____/____through_____/____/____

☐Discharge Summary ☐Emergency Room Records ☐Operative/Procedure Reports ☐Billing Records

☐Test Results (X-Rays, Lab/Pathology Results) Please specify: _____

☐Other (Immunization Records, Medication Lists) Please specify: _____

How would you like your records delivered?

☐Paper

☐Home Delivery

☐In-Person Pickup

☐Electronic (Email, USB, CD, Portal, Other) Please specify: _____

Where do you want the information sent? (Fill in boxes below):

ORGANIZATION NAME should provide my records to Self: ☐ Personal Representative (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)**
Signature of Patient or Personal Representative	**Date/Time**

Please return completed form to:

	E-mail: **Fax**:
	Questions?

Orlando Family Physicinas, LLC *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.*