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Patient Records Access Form

Patient's Name (Print): ________________________Patient's DOB: __________________

I would like to obtain a copy of my protected health information records at this practice.

I would like to obtain:

() My complete record at this practice

() My record for the time period ____________ to _____________

() A specific section of my record (please describe): __________________________

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() I would like to pick up the copy of my records on _______________________________

() Please mail the copy of my records to ____

() Please email the copy of my records to ____

_______________________________________ _______________________________

Signature of Patient/Guardian Date

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Please Print Name