Patient Self Request for Health Records Form

Please complete this form to request a copy of your medical records. This form is designed to be printed and filled out manually.

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1. Patient Information

First Name:

Middle Name:

Last Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Email Address:

Street Address:

City, State, Zip Code:

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2. Information Requested

Date Range of Records Requested (e.g., Jan 2020 to Present):

Type of Records Requested (e.g., Discharge Summary, Lab Results, Immunizations, Complete Chart):

Purpose of Request (e.g., Personal Use, Continuity of Care, Legal):

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3. Delivery Method

Preferred Delivery Method (e.g., Mail, Email, Secure Portal, In-Person Pickup):

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4. Patient Authorization

By signing below, I authorize the release of my health records as specified above.

Patient Signature (Sign within the box when printed):

Date of Signature (MM/DD/YYYY):