PRIMARY CARE PARTNERS

_____

PRACTICE NAME

REQUEST TO COPY PROTECTED HEALTH INFORMATION

Patient Name: _____

Acct #: _____

Date of Birth: _____

Patient Address: _____

Street

_____

Apartment #

_____

City, State, Zip

Send medical record to (if different from above):

_____

Name

_____

Street

_____

City, State, Zip

Reason for request:_____

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

Instructions for Medical Records Requests

Please mail the completed form to our office. Note that there may be a charge for copies per state Medical Society guidelines. If so, a staff member will contact you to review any charges.