

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:	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/ History and Physical			
Recipient Name:	Recipient Phone:		
Deciniont Mailing Address.	Recipient Fax:	Recipient Fax: Recipient E-mail (if applicable):	
Recipient Mailing Address:	necipient E-maii (ii 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.			

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