

**REQUEST FOR ACCESS TO MEDICAL RECORDS**

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| PATIENT NAME: |
| DOB: |
| ADDRESS: |
|  |
| TEL: |
|  |
| REQUEST RECEIVED FROM:  | PATIENT | 3rd PARTY |

**I confirm my consent to the release of my medical records:**

|  |  |
| --- | --- |
| FROM : *date* | TO: *date* |

Signed: …………………………………………………….. Date: ……………………………………………….

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| --- |
| **Email address to send records to:** |

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| --- |
| **OFFICE USE ONLY** |
| Date Request Received: |
| Date Patient Contacted: |
| Date Medical Records Printed/Copied: |
| Date of Redaction: |
| **Checked by:** |

|  |
| --- |
| **I confirm receipt of my medical records:**Signed: …………………………………………………….. Date: ………………………………………………. |

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| --- |
| ID VerificationPlease clip copy of ID taken to this form. |