HIPAA COMPLIANT REQUEST FOR MEDICAL RECORDS

DATE OF REQUEST: ____________

PATIENT INFORMATION

Patient Name:		
Patient Identification:	Social Security Number:	Date of Birth:
Reason for Request:		

FACILITY WHERE PATIENT'S RECORDS ARE LOCATED

Name	ExpressMed Urgent Care
Location (choose one):	☐ ExpressMed Hilliard ☐ ExpressMed Gahanna ☐ Both Locations

SEND THE FOLLOWING RECORD:

☐ All Medical Records (see below for restrictions):
☐ Specific Medical Records (i.e. X-Ray, Drug Screening, Worker's Comp) listed here:

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SEND ONLY THE ABOVE RECORDS FOR THE FOLLOWING DATES

Start Date (MM/DD/YYYY):____________________End Date (MM/DD/YYYY):____________________

SEND SPECIFIED AND AUTHORIZED MEDICAL RECORDS TO:

Name of Person/Organization/Clinic:	
Address:	
Telephone:	

DELIVERY METHOD:

☐ U.S. Mail
☐ Email (provide address here):____

I, (Patient Print Name) ____, hereby request and authorize the above medical records to be copied, released, and mailed to the indicated address above for the specified dates. I understand that the Health Insurance Portability and Accountability Act (HIPAA) applies to my medical records and my protected health information. I expect the holder of my medical records to mail my specified medical records as soon as reasonably possible, not to exceed 30 days, unless my records are off-site which allows for an additional 30 days. This authorization may be revoked by me, at any time, by notifying the doctor’s office (privacy officer) of this revocation in writing. I have been advised that if I chose to not authorize that I will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payments.

- ☐ I HAVE NO PROTECTED HEALTH INFORMATION WITHIN THE SPECIFIED TIME FRAME
  Release all of my medical records that have been indicated above
- ☐ I HAVE PROTECTED HEALTH INFORMATION WITHIN THE SPECIFIED TIME FRAME
  Release all of the above medical records for the specified time frame except for the following:

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Signature of Patient:____Date:______________________

Expiration Date for this Authorization:____