AUTH ON FILE

- NO
- YES
  - AUTHORIZED PERSON(S) _____
  - EXP: _____

REQUESTED:

DATE: _____

TIME: _____

Medical Records Request Form

In order to pick up any medical records you must present your ID and have an authorization and disclosure signed or sign one upon pick up. If you would like someone other than yourself to pick up these records you will have to sign an authorization and disclosure with the person's full legal name as it appears on their form of ID upon filling this form out. This person will need to present their ID upon picking your records up.

Note: Authorizations and disclosures are good for ONE year.

Please allow up to 14 days before your request is complete.

Last Name: _____ First Name: _____ M.I. ____

MR# _____ DOB: ____ /____ /_____ Phone Number: _____

Records Requested? _____

Report **CD** Date(s) of Service: _____

Where are the records going? ___ Patient to Pick-up

___ Mail to Patient (must have a valid auth.)

___ Send to Provider: _____ Fax: _____

___ Other: _____

Records Needed Immediately? **YES** **NO** Appt Date: _____

If yes, please state why: _____

Additional comments / Special instructions: _____

_____

_____

_____

_____

_____

_____

Office use only	
Employee Name and Department	**PATIENT STICKER** **(IF AVAILABLE)**