# Medical Record Request Form

Notice to patient: Use this form to obtain a copy of information maintained about you. This type of request is described in our practice's Notice of Privacy Practices.

**Patient Name**______________________________________________
[print or type]

**Description of Records Requested:**
*(Please describe the types of records requested. Please indicate the dates for which you are requesting records.)*

______________________________________________
______________________________________________
______________________________________________

**Scope of Request:** ____X____ I would like to *obtain a copy* of the requested records.

**Patient Information and Authorization:**

Print Name of Patient ______________________________

Signature of Patient ______________________________

Date of Birth ______________________________

Date of Request ______________________________

Name & Address where records will be sent:

______________________________
______________________________
______________________________
______________________________

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(INTERNAL OFFICE USE)

See telephone encounter to determine which specific records were sent.

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: ______________________________

Describe Personal Representative Relationship (parent, guardian, medical power of attorney, etc.): ______________________________

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.

Signature of Personal Representative: ______________________________

Date: ______________________________