

Request for Medical Records

Patient Name: _____ Date of Birth: _____

Phone Number _____ Last Four Digits of Social Security Number: _____

Address _____

Email Address _____

As the patient, or the patient's personal representative, I am requesting a copy of the medical record held by Baptist Health.

Facility: _____

Date(s) of Service Requested: _____

- Summary of Medical Record
 Entire Medical Record
 Emergency Room Record
 Radiology
 Laboratory
 Operative/Pathology Report
 Immunization Records
 Other Information: _____

Does request include a virtual visit?
Yes No

Please deliver to: Patient Other (Provide name and address)

I understand the record may include information relating to mental healthcare, communicable diseases, and treatment of alcohol or drug abuse. NOTICE: Once your PHI has been disclosed in accordance with this request, it may be re-disclosed to individuals or organizations that are not subject to the HIPAA regulations.

I request the record to be provided in the following format:

paper CD secure portal unsecure email fax (#_____)

I understand if I request the record to be provided by email that I undertake the following potential risks - the information may be obtained by someone else, the information can be opened and read by someone else, unencrypted information does not provide any assurance of privacy or security

Patient Signature

Date

Legal Representative, if not patient

Date

7/19