

## Patient Request for Health Information

Did you know you can request and access your medical records online through your patient portal? Visit: <https://livewell.aah.org>.  
(One Patient Per Form)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Treatment Facility/Physician: \_\_\_\_\_  
 Treatment Dates: \_\_\_\_\_

### Information Requested (select all that apply):

<b>Medical Records</b> <input type="checkbox"/> Facility Summary (Includes all items in <b>bold</b> ) <input type="checkbox"/> <b>Discharge Summary</b> <input type="checkbox"/> <b>History &amp; Physical</b> <input type="checkbox"/> <b>Consultation Reports</b> <input type="checkbox"/> <b>Office/Progress Notes</b> <input type="checkbox"/> <b>Emergency Record</b> <input type="checkbox"/> <b>Operative Reports</b> <input type="checkbox"/> <b>Laboratory Reports</b> <input type="checkbox"/> <b>Pathology Reports</b> <input type="checkbox"/> <b>Radiology Reports</b> <input type="checkbox"/> <b>Immunizations</b> <input type="checkbox"/> Sleep Study Reports <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Other _____	<b>Imaging (requires CD format)</b> <input type="checkbox"/> Radiology Images (X-Ray/CT/MRI/US) <input type="checkbox"/> Cardiology Images (Echo/Cath Lab) <input type="checkbox"/> Neurology Images (EEGs) <input type="checkbox"/> Fetal Ultrasound Images <input type="checkbox"/> Other Imaging: _____	<b>Billing</b> <input type="checkbox"/> Itemized Bill(s) <input type="checkbox"/> UB04 Form <input type="checkbox"/> CMS 1500 Form <input type="checkbox"/> Other Billing: _____
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### Send my requested information to:

☐ Myself  
☐ Other: \_\_\_\_\_  
 Name of Facility, Person, Company \_\_\_\_\_ Street Address or PO Box, City, State, Zip Code \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_ Email Address \_\_\_\_\_

### Requested Formt/Delivery Method: (Fees may apply)

<b>By Mail:</b> <input type="checkbox"/> Paper Copy <input type="checkbox"/> CD	<b>Electronically:</b> <input type="checkbox"/> Encrypted Email <input type="checkbox"/> Patient Portal	<b>Other:</b> <input type="checkbox"/> In Person Pick-up at: _____ <input type="checkbox"/> Paper <input type="checkbox"/> CD
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I understand the information to be disclosed may include information regarding genetic testing, genetic services and family medical history, mental health/developmental disabilities, Substance Use Disorder, HIV Test results and AIDS/AIDS-related illness.

Date _____	Time _____	Patient or Legal Representative Signature _____	Relationship to Patient _____
Print Name _____			

**Note:** If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign. Supporting documentation may be required.

**Minor Authorization:** If a minor consented to treatment by a licensed physician for pregnancy, sexually transmitted diseases, outpatient behavioral or mental health care, or outpatient treatment for controlled substances or alcohol without parental consent, the minor may sign this authorization. If the minor is receiving substance use disorder treatment with parental or guardian consent, both the minor and the parent or guardian may sign this authorization.

Date _____	Time _____	Signature of Minor _____
Print Name _____		

