

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):

Medical Records <input type="checkbox"/> Facility Summary (Includes all items in bold) <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History & Physical <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Office/Progress Notes <input type="checkbox"/> Emergency Record <input type="checkbox"/> Operative Reports <input type="checkbox"/> Laboratory Reports	Pathology Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Immunizations <input type="checkbox"/> Sleep Study Reports <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Other _____	Imaging (requires CD format) <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: _____	Billing <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 Format/Delivery Method: (Fees may apply)

By Mail:

- Paper Copy
- CD

Electronically:

- Encrypted Email
- Patient Portal

Other:

- In Person Pick-up at: _____
- Paper CD

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 _____

