Medical Record Request Form

Patient Information	
Patient’s Full Name:	
Date of Birth (mm/dd/yyyy):	
Patient’s ID Number (if applicable):	
Social Security Number (optional):	
Address:	
City, State, Zip:	
Phone Number:	
Email Address:	
Requestor’s Information (if not the patient)	
Full Name:	
Relationship to the Patient:	
Phone Number:	
Email Address:	
Address (if different from patient):	
Types of Records Requested	**Purpose of the Request**
☐ Clinical Notes ☐ Laboratory Test Results ☐ Imaging Studies (e.g., X-rays, MRIs) ☐ Prescription Records ☐ Immunization Records ☐ Entire Medical Record ☐ Other:	☐ Personal Use ☐ Continuation of Care ☐ Legal Matters ☐ Insurance Claim ☐ Other:
Preferred Delivery Method	
☐ Electronic Delivery (Email) ☐ Access via Patient Portal	☐ Mail Physical Copies ☐ Pick-Up in Person
Email Address / Pick-Up Details:	

Authorization

I, , hereby authorize the release of the medical records specified above. I understand that this authorization is voluntary and that I may revoke this authorization at any time by notifying the healthcare provider in writing, except to the extent that action has been taken in reliance on it.

- Signature of Patient or Authorized Representative:
- Date:
- Relationship to Patient (if not the patient):

Instructions for Healthcare Provider

Please process this request in accordance with applicable laws and regulations. If there are any fees associated with this request, kindly inform me in advance. The requested records should be provided within the timeframe mandated by law.

Office Use Only

- Date Received:
- Processed By:
- Date Fulfilled:
- Method of Delivery:
- Notes:

Contact Information for Questions or Concerns

Phone:

Email:

Signature of Witness (if required)

Date:

Please return this completed form to the healthcare provider's office via mail, fax, or in person. If you have any questions, do not hesitate to contact our office.