ROI

Patient Information (Please Print)			
First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

I am requesting my records from:

Facility Name: **Address:** **City/State Zip:**	**Facility E-mail:** **Facility Fax:**

What records do you want to receive or have disclosed to the recipient noted? (Check appropriate boxes below):

Date(s) of Service: ____/____/_____ through ____/____/_____

Progress Notes Emergency Room Record Discharge Summary History and Physical
Consultation(s) Lab Reports Pathology Report Operative Note(s) Imaging/X-Ray Films
Imaging/X-Ray Reports Entire Record Fetal Heart Monitor Strips
Other (specify)_____

_____

If it exists, the following Sensitive Information can be disclosed:

Alcohol Abuse Drug Abuse Communicable diseases, including HIV status
Genetic Testing Psychiatric/Behavioral Diagnoses

How would you like your records delivered?

Paper
Electronic: Email (I understand that there is a risk to me when my information is transmitted via an unsecured e-mail system, and the information could be accessed by a third party during the transmission process. By checking the box to request Email delivery I accept this risk.)
USB or CD
Password Protected Not Password Protected
Mail to address below I will pick up in person

If mailing, where do you want the information sent? (Fill in boxes below):

Please provide my records to: Myself Personal Representative (indicated below) Other Third Party (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	**Relationship (please print)**

Patient's Signature or Legal Representative		Date/Time
Relationship to Patient / Authority to Act on Patient's Behalf	Interpreter, if Utilized	Date/Time
Witness Signature		Date/Time

This Healthcare Facility recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

Patient Label