# Patient Request for Medical Records

Patient Last Name:_____ First Name:_____Middle Name:_____

Patient Date of Birth _____/____/_____Other names, if applicable (i.e. maiden)_____

Patient Address:_____

Patient Phone:_____

Records are to be (Please initial next to preferred method of delivery):

____ Mailed to the following address:_____

____ Faxed to the following fax number: (_____) _____-_____

____ Picked up (Required for electronic copies)

Description of records being requested (Please initial next to type(s) of records requested) :

____ For time period beginning _____/____/_____ to _____/____/_____

____ For specific condition(s):_____

____ Billing Records Only

____ Imaging/Labs/Diagnostic Records Only

____ All records relating to patient care delivered by Rehabilitation Medicine Associates

____ Other (Please specify):_____

Please note: RMA may deny this request under limited circumstances as provided in federal regulations governing the use and disclosure of protected health information. I understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed independent practitioner selected by RMA who did not participate in the decision to deny my request.

_____ _____

Date Signature (Patient or Other Authorized Representative)

_____ _____

Printed Name Relationship to Patient (Self, Parent, Other)