



### Request for Medical Records

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone Number \_\_\_\_\_ Last Four Digits of Social Security Number: \_\_\_\_\_

Address \_\_\_\_\_

Email Address \_\_\_\_\_

As the patient, or the patient's personal representative, I am requesting a copy of the medical record held by Baptist Health.

Facility: \_\_\_\_\_

Date(s) of Service Requested: \_\_\_\_\_

\_\_\_\_ Summary of Medical Record

\_\_\_\_ Entire Medical Record

\_\_\_\_ Emergency Room Record

\_\_\_\_ Radiology

\_\_\_\_ Laboratory

\_\_\_\_ Operative/Pathology Report

\_\_\_\_ Immunization Records

\_\_\_\_ Other Information: \_\_\_\_\_

Does request include a virtual visit?

Yes

No

Please deliver to: \_\_\_\_\_ Patient \_\_\_\_\_ Other (Provide name and address)

\_\_\_\_\_  
\_\_\_\_\_

I understand the record may include information relating to mental healthcare, communicable diseases, and treatment of alcohol or drug abuse. NOTICE: Once your PHI has been disclosed in accordance with this request, it may be re-disclosed to individuals or organizations that are not subject to the HIPAA regulations.

I request the record to be provided in the following format:

\_\_ paper \_\_ CD \_\_ secure portal \_\_ unsecure email \_\_ fax (# \_\_\_\_\_)

I understand if I request the record to be provided by email that I undertake the following potential risks - the information may be obtained by someone else, the information can be opened and read by someone else, unencrypted information does not provide any assurance of privacy or security

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Representative, if not patient

\_\_\_\_\_  
Date