



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:	Facility E-mail:		
Address:	Facility Fax:		
City/State Zip:			
What records do you want to receive or have disclosed to the recipient noted? (Check appropriate boxes below):			
Date(s) of Service: ____/____/____ through ____/____/____			
<input type="checkbox"/> Progress Notes <input type="checkbox"/> Emergency Room Record <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History and Physical <input type="checkbox"/> Consultation(s) <input type="checkbox"/> Lab Reports <input type="checkbox"/> Pathology Report <input type="checkbox"/> Operative Note(s) <input type="checkbox"/> Imaging/X-Ray Films <input type="checkbox"/> Imaging/X-Ray Reports <input type="checkbox"/> Entire Record <input type="checkbox"/> Fetal Heart Monitor Strips <input type="checkbox"/> Other (specify) _____			
If it exists, the following Sensitive Information can be disclosed:			
<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Communicable diseases, including HIV status <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Psychiatric/Behavioral Diagnoses			
How would you like your records delivered?			
<input type="checkbox"/> Paper <input type="checkbox"/> Electronic: <input type="checkbox"/> 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.) <input type="checkbox"/> Removable Media (i.e. DVD, USB, CD-ROM, etc.) <input type="checkbox"/> Password Protected <input type="checkbox"/> Not Password Protected <input type="checkbox"/> Mail to address below <input type="checkbox"/> I will pick up in person			
If mailing, where do you want the information sent? (Fill in boxes below):			
Please provide my records to: <input type="checkbox"/> Myself <input type="checkbox"/> Personal Representative (indicated below) <input type="checkbox"/> 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	
<i>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.</i>			