REQUEST FOR MEDICAL RECORDS

Patient Name: ____

Date of Birth: ____

Date of Request: ____

As allowed by the Privacy Regulations, I wish to access the following information contained in my **Protected Health Records**: (Please be specific)

Charges

I understand that I may be charged a reasonable administrative fee for any additional requests, after the initial request for these records. I agree to pay this fee, prior to receipt of the requested records.

Response

I understand that you will grant or deny this request within 5 business days from receipt of the request. Any denial will be in writing with an explanation, as required by the Privacy Regulations.

Check Here ( ) I would like a copy of the above information sent to me at the following address:

Address: ____________ City: _______________ State: _____ Zip: ____________

_____________________________ ____________________

Patient Signature Date

Check Here ( ) I would like a copy of the above information sent to me via email to the following email address.: ____

Email

To protect patient confidentiality, IDS normally mails requested records to the recipient, as email is not considered a secure communication method. If requesting receipt via email, I understand that medical records do include confidential information including Protected Health Information (PHI) and that email is not secure. By signing below, I am giving permission for the requested records to be sent to the email address provided above and releasing Instant Diagnostic Systems Inc. of all liability for the security of this communication method.

____ ________________________

Patient Signature Date

____ ________________________

Authorized Signature of Facility Date

Please return the signed form to:
Fax: 1-888-213-9196
Email: support@instantdiagnostic.com

1740 4th Ave. SE Ste A● Decatur, AL ● (800) 355-0691
www.instantdiagnostic.com