# Medical Records Request Form

*This form is used to request copies of medical records. Only patient or their legal representative may make a medical record request. Some requests may be subject to a reasonable fee. Please print.*

## Patient Information

Name: _____Date of birth (MM/DD/YYYY)_____

Address:_____Phone:_____

City:_____State_____Zip_____

**What information are your requesting?** (Mark all that apply)

Date(s) of service_____

| | | |
|---|---|---|
| ☐ Physician office notes | ☐ Pathology Reports | ☐ Surgical Notes |
| ☐ Lab reports | ☐ EKG/Cardiology Reports | ☐ Billing (Claim) |
| ☐ X-Ray reports | ☐ Consult notes | ☐ Other |
| ☐ Other Diagnostic Studies | ☐ Physical Therapy Notes | ☐All health information |

**Purpose of Disclosure:** (Please select only one box)

| | | |
|---|---|---|
| ☐ Personal Use (Skip Part 4 below) | ☐ Insurance | ☐ School |
| ☐ Treatment/Continuing Medical Care | ☐ Legal Purpose | ☐ Employment |
| ☐ Billing or Claims | ☐ Disability Determination | ☐ Other |

**This section to be completed only for third-party disclosures.** (If disclosure is for personal use, skip this section)

Have the requested medical records sent to the third-party noted below. My completion of this form is authorization for Salcido Family Medicine to disclose the records to the person or group.

Name_____ Phone_____

Fax #_____ or email address_____

**Term of Authorization:** I understand this authorization may be revoked in writing at any time. Unless otherwise revoked, this authorization will expire in 180 days. If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulation, the information described may be re-disclosed and no longer protected by those regulations. This information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care. Request may take as long as 15 days.

Patient Signature_____ Date _____

Printed Name _____Relationship to Patient _____

***Email request to MedicalRecords@DrSalcido.com***