

PATIENT DIRECTED REQUEST

*Indicates a REQUIRED field.

Completion of this document authorizes the disclosure and use of health information about you.

Failure to provide all information requested may invalidate this request.

*Patient Name: _____ Medical Record #: _____

*Address: _____ *Date of Birth: _____

*City/State/Zip: _____ Phone: _____

Where do you want the information sent? (This patient directed request is used only when a patient is asking for their own records or directing them to be sent to a third party.)

*Recipient Name: _____

*Recipient Phone: _____

*Recipient Mailing Address: _____

*Recipient Email (if applicable): _____

***Check Delivery Option:**
 Paper Copy / Pick Up or Mail
 Providers Fax # _____
 E-Mail (Encrypted/Patient or Continuity of Care Only) _____

***What records do you want? (Check appropriate boxes below):**

Location: _____

Date(s) of Service: ____ / ____ / ____ through ____ / ____ / ____

- Discharge Summary Emergency Room Records
- Operative/Procedure Reports
- Test Results (X-Rays, Lab/Pathology Results). Please specify: _____
- Mental health/Alcohol/drug treatment information
- HIV test results Genetic Testing Information Reproductive health records
- Other (Immunization Records, Medication Lists, Continuity of Care Document). Please specify: _____

I authorize _____ **to pick up my medical records.**

***Signature:** _____
(Patient/Parent/Conservator/Guardian) Date/Time

***Print Name:** _____ **Relationship** _____



Authorization to
Release Medical Info

Adventist Health
PATIENT DIRECTED REQUEST
(05/23) – 8707F2916

PATIENT LABEL