ClearPath Family Healthcare

2021

REQUEST FOR MEDICAL RECORDS

PART A: Patient Information (Please Print)

Patient Name: _____
Date of Birth: _____
Contact Number: _____
Address:_____
State _____ Zip _____

PART B: Scope of Access Request

I request a copy of my protected health information held by:

_____
_____
_____

I request the following protected health information

Last 2 years of office notes
Last year of lab reports
Preventative reports to include
(last colonoscopy, mammogram, dexa, diabetic eye exam)
Last 2 years or radiology reports
Other _____
_____
_____

PART C: Manner of Access

I would like to receive my records in the following format:

- [ ] Secure Email to: _____
- [ ] Secure Fax:_____
- [ ] In-person Pickup (may have a fee):

By signing this form, I authorize the release protected health information about me (or another person for whom I have given authority to sign) to the ClearPath Family Healthcare for the time period, purpose, and extent described above. My signature indicates that I fully understand and acknowledge the following:

- My health record may include information relating to sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, blood alcohol and drug testing, and treatment for alcohol and drug abuse.
- The protected health information to be used or disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law.
- I have the right to refuse to sign this authorization. CP will not condition treatment, payment, enrollment, or benefits eligibility on my signing this authorization.
- I have the right to revoke this authorization in writing at any time to the extent that the use or disclosure has not already been made. I may do so in person at the office where my records are maintained.
- CP may charge a fee for copies of requested health information to cover cost of labor, supplies, and/or postage, if mailed to you. We will inform you of the total charges before providing the requested copies.

_____
Signature of Patient or Legal Representative

_____
Relationship to patient (if representative)

_____
Date