Patient Request for Health Information

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:

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

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

☐ Discharge Summary ☐ Progress Notes/Office Visits ☐ Operative/Procedure Reports ☐ Billing Records

☐ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____

☐ Other (Immunization Records, Medication Lists) Please specify: _____

How would you like your records delivered?

☐ Paper

☐ Home Delivery

☐ In-Person Pickup

☐ Electronic (Email, USB, CD, Portal, Other) Please specify: _____

Where do you want the information sent? (Fill in boxes below):

ORGANIZATION NAME should provide my records to: ☐ Self ☐ Personal Representative (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)**
Signature of Patient or Personal Representative	**Date/Time**

Records needed from which Doctor/Facility?

	E-mail: **Fax:**
	Questions?

Acton Corporation *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.*

- Incomplete or illegible forms could delay the process.
- Emailed links are secure and allow for faster delivery.
- Average turnaround is 24-48 hours once received.

888.678.7227

Acton

Treating Information with Care