REQUEST FOR MY MEDICAL RECORDS

Name of Doctor or Health Facility: _____ Date: _____
Address: _____
_____

To whom it may concern:

The purpose of this letter is to request copies of my medical records as allowed by the Department of Health and Human Services and HIPAA regulations.

Patient's Name: _____
Address: _____
_____
Date of Birth: _____

Medical identification number: _____ (or) Social Security Number:_____

Purpose: Personal Use

Select one:

☐ I was treated in your practice or facility from ___/___/20___ to ___/___/ 20___. I request copies of all health records.

☐ I was treated in your practice or facility from ___/___/20___ to ___/___/ 20___. I request copies of the following health records related to my treatment for _____.

- ☐ Medical History Form
- ☐ Test results
- ☐ Treatments
- ☐ X-ray MRI Reports
- ☐ Physician's/ Nurses Notes

☐Summary of medical records. (I understand there may be an additional charge allowed)

I understand that under HIPAA I can be charged a reasonable fee for copying records. I may also be charged for postage if the records are mailed to me. HIPAA allows 30 days for you to respond to my request for records, with one 30-day extension for good reason. Please mail the requested records to me at the above address. Please inform me of the method of payment.

☐ I will pick the records up from your office.

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☐ Please fax to MM Medical llc 1 (815) 366 7913.

Please inform me of the date I might expect to receive my records.

Sincerely,

Signed_____

Print Name _____