

Patient Request for Access/Copy of Medical Record

Note: Patients requesting a copy of their Medical Record must submit this completed form.

Patient Information

Name (First, Middle, Last)	
Address Line 1	
Address Line 2	
Phone (Home)	
Phone (Mobile)	
Date of Birth	
Social Security Number	
Patient Record Number (if known)	

I hereby request access a copy of my medical record and request that my record be delivered to the following person and at the address below (and contact information if the address is not my home address):

Name (First, Middle, Last)	
Address Line 1	
Address Line 2	
Phone (Home)	
Phone (Mobile)	

I request a copy of my medical record in the following format:

Paper	
Encrypted email	
Encrypted USB	
Encrypted DVD	

I understand that my medical record will be provided in a paper copy unless another format is requested by me.

I also understand that if I request an electronic copy, delivered either by mail or electronically, then the copy will be provided in an encrypted format with the decryption key delivered separately.

If I refuse encryption of my electronic information, I understand that my electronic record will not be secure and I hereby release and forever waive any claims that may arise or that I may have had at any time with regard to an unsecure copy of my electronic health record or unsecure delivery of my electronic health record and that in the event of a breach of such electronic health record, Arizona Blood & Cancer Specialists is released from any obligations or liability arising under any federal or state law.

(Date)

(Signature of Individual or Patient Representative)

If signed by a Personal Representative, please complete the information below:	
If you are signing as a Power of Attorney, Legal guardian, Executor, or Administrator, attach a copy of the legal documents. You do NOT have to attach copies of these documents if they are already on file with Arizona Breast Health Specialists.	
_____ Personal Representative's Name	_____ Relationship to Individual
_____ Personal Representative's Address	_____ City, State, ZIP
_____ Personal Representative's Telephone Number	_____ Personal Representative's E-mail address (optional)