Date:

To:

Re: Request for Records in Electronic Format

Dear Records Custodian,

I, _____, date of birth _____, request copies of any and all of my records and am requesting they be delivered in an electronic form.

By this release or a copy and/or facsimile thereof, I am requesting you to release in an electronic format my complete records/charts/files, relative to all dates of confinement, treatment, or service, including (but not limited to):

I understand my medical information may be re-disclosed and may not be protected under federal or state laws protecting health care information. I understand that at any time I have the right to revoke this authorization in writing and can refer to the Privacy Notice to patients posted at the facility from which information is being released. I realize I am entitled to a copy of this release/authorization. I understand that the disclosure of this information or refusal to sign this authorization will not affect my ability to obtain health care services or reimbursement for services. A copy or fax shall be considered valid in lieu of the original. This authorization expires two (2) calendar years from the date signed. I understand the information to be used or disclosed pursuant to this authorization form may include information relating to diagnosis, test results, or treatment for (EXCLUDE records if checked):
☐ STD/HIV/AIDS, ☐ Drug or Alcohol Abuse, ☐ Mental or Behavioral Health or Psychiatric Care,
☐ Genetic Test Results; ☐ Contraception and/or Prenatal Care.

You are specifically authorized to speak with the following individuals regarding my treatment, services, and/or records and answer any questions they may have:

_____

In accordance with 42 U.S.C. 17935 (e) and 45 C.F.R. 164.524 I specifically request that you certify my records and provide them in electronic format only. ***Do not send paper copies.*** In order of preference:

1. Emailed to:
2. Faxed to:
3. Thumb drive/disk mailed to:

In accordance with HIPAA laws and regulations, these records are for coordination and/or continuity of care, including by social services providers.

I am indigent. If there are any fees above $10.00, email a pre-payment notice. *Do not release records without prior fee approval if more than $10.00. I am not responsible for fees above $10 without prior authorization.*

Thank you in advance for your quick attention to this request. Should you have any questions or need additional information, please contact:

Thank you,

_____ _____

Signature Date

_____ _____

Witness Date