Baptist Health
all our best

Request for Medical Records

Patient Name: _____ Date of Birth:_____

Phone Number_____ Last Four Digits of Social Security Number:_____

Address_____

Email Address_____

As the patient, or the patient's personal representative, I am requesting a copy of the medical record held by Baptist Health.

Facility: _____

Date(s) of Service Requested: _____

_____ Summary of Medical Record
_____ Entire Medical Record
_____ Emergency Room Record
_____ Radiology
_____ Laboratory
_____ Operative/Pathology Report
_____ Immunization Records
_____ Other Information: _____

Does request include a virtual visit?
Yes No

Please deliver to: _____ Patient _____ Other (Provide name and address)

_____

_____

I understand the record may include information relating to mental healthcare, communicable diseases, and treatment of alcohol or drug abuse. NOTICE: Once your PHI has been disclosed in accordance with this request, it may be re-disclosed to individuals or organizations that are not subject to the HIPAA regulations.

I request the record to be provided in the following format:

__ paper ___ CD ___ secure portal ___ unsecure email ____ fax (#_____)

I understand if I request the record to be provided by email that I undertake the following potential risks - the information may be obtained by someone else, the information can be opened and read by someone else, unencrypted information does not provide any assurance of privacy or security

_____ _____
Patient Signature Date

_____ _____
Legal Representative, if not patient Date