STAT REQUEST

MEDICAL RECORDS RELEASE AUTHORIZATION

"I hereby authorize and request you to please release a complete copy of my medical records to":

The Health Center

5370 Pearl Road

Parma, Ohio 44129

P: 440-809-8450 F: 216-539-8637

The Health Center is requesting you please fax the patient's last 3 (three) completed office chart notes.

Federal HIPAA law mandates a maximum 30-day period for accessing medical records.
Once a patient requests their medical record, the healthcare provider has 30 days to furnish it.

Name of Patient: _____

Patient's date of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Signature of Patient or Patient's Legal Representative: _____

Print Your Name if Legal Representative: _____

Relationship to Patient: _____

Today's Date: _____

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First and Last Name of the Physician (or Hospital) From Whom You Are Requesting Records:

_____

Address of the Physician or Hospital:

_____

Phone Number of Physician's Office: _____

Fax Number of Physician's Office: _____