PATIENT MEDICAL RECORDS REQUEST FORM

Our Medical Records Request Form allows you to obtain copies of your medical records from the Cancer and Blood Specialty Clinic. Medical records contain vital information about your health history, diagnoses, treatments, and medications. By completing this form, you can request access to your records for personal review, continuity of care, or to share with other healthcare providers as needed. Your medical records are confidential and protected by privacy laws, and our clinic is committed to ensuring the security and privacy of your health information. Simply fill out the form and our staff will process your request promptly. We understand the importance of having access to your medical history, and we are here to assist you in obtaining the information you need for your continued care.

Please note: Records are available for pick-up in-office only. Processing times may vary.

Full Name:	
DOB:	
Specific Records Requested: *Please ensure that you provide specific dates and specify the exact records required in addition to checking the checkbox options provided. This will help us process your request accurately and efficiently.*	☐ Consultation Notes: _____ ☐ Progress Notes: _____ ☐ Lab Results: _____ ☐ Imaging Results: _____ ☐ Pathology Results: _____ ☐ Medication History: _____ ☐ Other: _____

PURPOSE OF REQUEST

☐ Personal Review
☐ Continuity of Care
☐ Second Opinion
☐ Legal Purposes
☐ Other (Please specify): _____

DESIGNATED INDIVIDUALS (IF APPLICABLE)

If you are designating another individual to receive these records, please provide their contact information and indicate your relationship to them in this section.

Full Name:	
Relationship to Patient:	
Contact Information:	

SIGNATURE

Before signing, please review your selections and ensure that all necessary information is provided to accurately fulfill your medical records request.

Patient Signature:		**Date:**	

KEEP FOR YOUR RECORDS