Memorial PRIMARY CARE | URBANA

900 Scioto Street,
Urbana, OH 43078
937 652 1834

REQUEST FOR MEDICAL RECORDS

I _____ _____ _____
(Name of Patient) (Date of Birth) (Social Security Nr.)

_____ _____
(Telephone Number) (Other Name)

Authorize:

Name:_____

Address:_____

City, ST, ZIP_____

To Send To:

Memorial Primary Care | Urbana
900 Scioto Street
Urbana, Ohio 43078

_____ On Site review of the above patient's health care records. (Insurance Company Request)
_____ Release of information of the following from the above patient's health care records.
_____Medical History, if any of the below apply, please check also:
_____ Alcohol and/or Drug Dependency Records
_____ Mental Health Treatment Records (Specific Diagnosis_____)
_____ HIV (AIDS) Antibody Test Results and Diagnosis/Treatment Records
_____ Other_____
____ Electronic Copy of Your Health Information

This disclosure is being made for the following purpose:
___ Transfer of care; ___ Continuing care; ___ Insurance or payment issues;
___ Attorney/Court request ___Personal Reasons

This request/authorization is valid for one year from the date signed. This informed consent is subject to revocation at any time by written notification only.

X_____ _____
Signature of Patient or Legal Representative Date

X_____ _____
Witness Signature Date

Relationship: ___ Legal Guardian ___ Spouse of Deceased ___ Executor of Estate

___ Power of attorney for healthcare ___ Self ___ Other _____