University Medical Center

Updated as of 9/13/17
Supersedes all prior versions

University Medical Center (UMC) Patient Request for Health Information

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):
Date(s) of Service: _____/_____/_____ through _____/_____/_____

☐ Office note ☐Lab ☐ Immunizations ☐ X-ray ☐ Billing ☐ Other: (Please specify): _____

How would you like to have your records delivered? (Check appropriate boxes below):

☐ Paper ☐ Home Delivery ☐ In-Person Pickup ☐ Fax number: (_____) _____

☐ Electronic (Email, USB, CD, Portal, Other: Please specify: _____)

UMC should provide records to:

☐ Self ☐ Personal Representatives *Personal representatives are 1) individuals with authority to act on behalf of an adult or emancipated minor in making decisions related to healthcare, 2) executors or administrators acting on behalf of a deceased individual or individual's estate, 3) someone involved in the patient's health care or payment.

☐ Third Party * Check this box only if the patient or personal representative has requested release to a third party. Examples of third party: personal attorney, relative.

Where do you want the information sent: (Fill in boxes below):

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	**Relationship (please print)**
Signature of Patient or Personal Representative	**Date/Time**

Please return completed form to:

	E-mail: Fax:
	Questions?

UMC recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

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