



ROI

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 ___/___/___			
<input type="checkbox"/> Progress Notes <input type="checkbox"/> Emergency Room Record <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History and Physical <input type="checkbox"/> Consultation(s) <input type="checkbox"/> Lab Reports <input type="checkbox"/> Pathology Report <input type="checkbox"/> Operative Note(s) <input type="checkbox"/> Imaging/X-Ray Films <input type="checkbox"/> Imaging/X-Ray Reports <input type="checkbox"/> Entire Record <input type="checkbox"/> Fetal Heart Monitor Strips			
Sensitive Information:			
<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Communicable diseases, including HIV status <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Psychiatric/Behavioral Diagnoses Other (specify) _____			
How would you like your records delivered?			
<input type="checkbox"/> Paper <input type="checkbox"/> Electronic: Email (I understand that there is a risk to me when my information is transmitted via an unsecured e-mail system, and the information could be accessed by a third party during the transmission process. By checking the box to request Email delivery I accept this risk.) <input type="checkbox"/> USB or CD <input type="checkbox"/> Password Protected <input type="checkbox"/> Not Password Protected <input type="checkbox"/> Mail to address below <input type="checkbox"/> I will pick up in person			
If mailing, where do you want the information sent? (Fill in boxes below):			
Please provide my records to: <input type="checkbox"/> Myself <input type="checkbox"/> Personal Representative (indicated below) <input type="checkbox"/> Other Third Party			
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:			
Facility Name:		E-mail:	
Address:		Fax:	
City/State Zip:			
<i>This Healthcare Facility 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.</i>			