Medical Records Request Form Online

Patient Details

Full Name: ____

Date of Birth: ____

Phone Number: ____

Email Address: ____

Facility Information

Facility Name: ____

Address: ____

Phone Number: ____

Request Details

Type of Records Requested:

☐ **General Medical Records**

☐ **Diagnostic Reports**

☐ **Billing Statements**

☐ **Other:** ____

Purpose of Request:

☐ **Personal Use**

☐ **Legal Case**

☐ **Continuation of Care**

☐ **Insurance**

Preferred Delivery Method

☐ **Secure Online Portal (Email Address Required)**

☐ **Physical Copies by Mail**

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Acknowledgment

☐ **I confirm this request complies with applicable laws and privacy regulations.**

Signature: ___________________________ Date: _________________________

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