Medical Records Request Form

This form is used to request copies of medical records. Only patients or their legal representatives may make a medical record request. Somers Pediatrics may verify your identity/guardianship. Some requests may be subject to a reasonable fee. Please print.

Part 1: Patient Information Name:_____ Date of birth (MM/DD/YYYY): _____

Address:_____ Phone:_____

City:_____ State:_____ ZIP:_____

Part 2: What information are you requesting? (Mark all that apply)

Date(s) of service:_____

- ☐ Clinic/ Outpatient Record. Clinic:_____ Provider:_____
- ☐ Inpatient Abstract (includes face sheet, discharge summary, history and physical exam, operative and pathology reports, consultation reports, radiology reports and EEGs)

- ☐ Discharge Summary
- ☐ History/Physical Exam
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Consultation Reports
- ☐ Radiology Reports & Images
- ☐ EKG/Cardiology Reports
- ☐ Lab Results
- ☐ Progress Notes
- ☐ Past/Present Medications
- ☐ Patient Allergies
- ☐ Billing (Claim) Information
- ☐ Other_____
- ☐ **All health information**

Mental/behavioral health records (may require physician/psychologist approval):
☐Psychiatric/mental health records ☐Neuropsychological testing ☐Other _

Part 3: Purpose of Disclosure: (Please select only one box)

- ☐ Personal Use
- ☐ Treatment/Continuing Medical Care
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

Part 4: Terms of Authorization: I understand this authorization may be revoked in writing at any time, according to the instructions in Somers Pediatrics Notice of Privacy Practices, except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the sooner of 180 days from the date of this authorization or on the date indicated here:_____ If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes. Somers Pediatrics will not condition treatment or payment on my completion of this form.

Signature:_____ Date:_____

Printed name:_____ Relationship to patient: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, Tex. Fam. Code §32.003).

Minor's Signature:_____ Date:_____