HSDC
Hearing, Speech & Deaf Center

PATIENT RECORD REQUEST FORM

You have the right to inspect and obtain a copy of your medical and billing records that we maintain. If you request copies of your records, we will notify you of any charge.

Patient Information: (Individual whose information will be released)

Name: _____ **Date of Birth:** _____
(First, Middle, Last) (Month/Day/Year)

Address: _____
(street, city, state, zip code)

Description of requested records:

_____

_____

Records requested from: _____ **to** _____
(Date) (Date)

Please indicate whether you want to inspect your records or obtain a copy of your records:

☐ Inspect

Obtain a copy on:

- ☐ Paper records
- ☐ Unencrypted email (By choosing this option, you understand that there is a risk that the requested information could be viewed by an unauthorized person when transmitted over the internet)
- ☐ Other preferred form/format *(subject to approval)*:

If you are requesting to obtain a copy:

☐ For pickup

☐ Mail to the following physical address:

_____
name

_____
street city state zip code

☐ Email or send secure message to the following email address: _____

Print Name: _____

Relationship (if authorized representative of patient): _____

Signature: _____ **Date:** _____

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the patient (e.g., Health care Power of Attorney).