Request for my/my child's Protected Health Information (PHI)

9300 Valley Children's Place, Madera, California 93638-8762
Telephone: 559-353-5414 Fax: 559-353-5418

I hereby request specific health information identified below for:

_____ _____ (____) _____

Patient Name ***Date of Birth*** ***Telephone/Cell***

Email: _____

I specifically request the following health information to the extent such information and/or medical records exist. Please specify what health information that you would like to request:

Type of Information	[X] which apply	**Dates Requested**
History & Physical (admission)		
Emergency Room Report		
Discharge Summary		
Consultations		
Operative Reports		
Clinic Summaries		
Laboratory Reports		
Radiology Reports		
Billing Records		
Radiology Films /Images		
Pathology Slides		
Visit History		
Pertinent Information		
Other:		

I request my records by: MyChart [ ] CD [ ] Paper [ ] Fax: _____

[ ] Secure Email [ ] Non/Secure Email [ ] Electronically to my App

_____

Date: _____ Time: _____AM/PM

Patient/Legal Representative Signature: _____

_____

Please state your legal relationship to the patient: _____

Release of Information Staff Signature: Identification Verified Yes [ ]

_____