Medical Annex ◆ 4813 New Haven Ave. ◆ Fort Wayne, IN 46803

Phone: (260) 449-7504 ◆ Fax: (260) 449-3813 ◆ www.allencountyhealth.com

Request for Medical Record Information

I am requesting the following information from **my/my child's** medical record concerning testing, treatment, diagnosis and services **I/my child** have/has received during the period from _____ to _____.

Patient's Name _____

Date of Birth_____ Telephone_____ S.S.#_____

Address_____ City/State/Zip_____

I am requesting the following information:

☐ HIV Testing/Results ☐ Hepatitis Testing/Results ☐ Diagnosis and Treatment
☐ TB Testing/Results ☐ Laboratory Tests/Results ☐ Immunization Record
☐ Blood Lead Level/Results ☐ Other _____

I would like to: ☐ Inspect these records. ☐ Obtain a copy of these records. ☐ Both.

I would like to receive copies of the medical records in the following manner:

☐ In-person pick up

☐ Mailed to my home address (Records will be sent to the address listed above)

☐ Electronically* E-Mail: _____

☐ Other _____

* If you elect to receive information via email, there is an increased risk that it could be received or viewed by unauthorized persons.

There will be a small fee to obtain a copy of these records including the cost of postage if mailed to you.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

This request is valid for 60 days from the date above.

MUST PRESENT CURRENT I.D

……..……..……--For office use below this line--…….……..

Date Request Received: _____ Received By: ___*Fax* ___*E-Mail* ___*US Mail* ___*Hand Delivery* ___*Other*

Signature of Employee authorizing the release of medical information:_____

Date Released: _____ ***By:*** *Fax E-Mail US Mail Cert Mail Picked Up Other* _____

Was this form uploaded to Athena: _____Yes _____ No

NOTES: _____