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Records Request Form

Name: _____ DOB: _____ today's Date: _____

1. Request and Authorize Dr. Hernandez/Dr. Ashley to: ☐ Release ☐ Obtain From:

Name _____

Address: _____

Fax Number: _____

2. The Purpose of this Request is:

Transfer of Medical Care: _____Personal Use: _____Other (reason required): _____

3. Medical Records to be Released or Obtained:

All Medical Records _____ Specific Dates / Record: _____

4. Method of Delivery of Requested Medical Records:

Mail: _____ Pick UP: _____ Fax: _____

5. Expiration Date of This Authorization

☐ 1 year from today

☐ Specific Date: _____

☐ Until revoked in writing

6. Patient Acknowledgment and Disclosures

By signing below, I understand:

- This release is voluntary.
- I may revoke it at any time in writing.
- Once released, my records may no longer be protected by federal privacy laws (HIPAA).

Patient Signature: _____ **Date**: _____

If signing for someone else, relationship to patient: _____